CONTRACT BETWEEN

THE STATE OF MISSISSIPPI DIVISION OF MEDICAID OFFICE OF THE GOVERNOR

AND

A COORDINATED CARE ORGANIZATION (CCO)

(Contractor)

State of Mississippi

Office of the Governor

Division of Medicaid

Walter Sillers Building

550 High Street, Suite 1000

Jackson, MS 39201-1399

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CONTRACT BETWEEN THE STATE OF MISSISSIPPI DIVISION OF MEDICAID, OFFICE OF THE GOVERNOR

AND _____

This Contract is entered into this _____ day of _____, 2014 between the State of Mississippi, Office of the Governor, Division of Medicaid, with a principal place of business located at 550 High Street in the City of Jackson, County of Hinds, State of Mississippi and _____, a corporation organized and existing pursuant to the laws of the State of Mississippi, which is licensed as defined by the Department of Insurance**,** with a principal place of business located at, in the City of _____, County of _____ State of _____.

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

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

WHEREAS, the Division desires to contract with a Coordinated Care Organization (Contractor) to obtain services for the benefit of certain Medicaid beneficiaries and the Contractor has provided to the Division continuing proof of the Contractor's financial responsibility, including adequate protection against the risk of Insolvency, and its capability to provide quality services efficiently, effectively and economically during the term of this Contract, upon which the Division relies in entering into this Contract.

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

SECTION 1 – GENERAL PROVISIONS

A. **Term**

The Contract period begins July 1, 2014 and shall terminate on June 30, 2017. The Division may have, under the same terms and conditions as the existing Contract, an option for two (2) one-year extensions.

B. **Definitions and Construction**

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

In the event of a conflict between this Contract and the various documents incorporated into this Contract by reference, the terms of this Contract shall govern.

This Contract between the State of Mississippi and the Contractor consists of 1) this Contract and any amendments thereto; 2) the MississippiCAN Program RFP and any amendments thereto; 3) the Contractor's Proposal submitted in response to the RFP by reference and as an integral part of this Contract; 4) written questions and answers. In the event of a conflict in language among the four (4) documents referenced above, the provisions and requirements set forth and/or referenced in the Contract and its amendments shall govern. After the Contract, the order of priority shall be as follows: the RFP Bidder Questions and Answers, the Contractor's Proposal and its attachments, and the RFP. In the event that an issue is addressed in one (1) document that is not addressed in another document, no conflict in language shall be deemed to occur. All the documents shall be read and construed as far as possible to be one harmonious whole; however, in the event of a conflict or dispute, the above list is the list of priority.

However, the Division reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict or ambiguity with the applicable requirements stated in the RFP or the Contractor's Proposal. In all other matters not affected by the written clarification, if any, the RFP and its amendments shall govern.

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

The Division reserves the right to review the existing contract semiannually to address contract and/or program vulnerabilities and discrepancies. No modification or change of any provision in the Contract shall be made, or construed to have been made, unless such modification or change is mutually agreed upon in writing by the Contractor and the Division. The agreed upon modification or change will be incorporated as a written Contract amendment and processed through the Division for approval prior to the effective date of such modification or change. In some instances, the Contract

amendment must be approved by CMS before the change becomes effective.

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

Contractor: Person(s) designated by the Contractor

Division of Medicaid: Executive Director

C. **State and Federal Law**

At all times during the term of this Contract and in the performance of every aspect of this Contract, the Contract shall be governed by and construed in accordance with the laws of the State of Mississippi, excluding its conflict of law provisions, and any litigation with respect thereto shall be brought in the courts of the State of Mississippi.

The Contractor shall comply with all applicable Federal, State, and local laws and regulations and standards, as have been or may hereinafter be established, specifically including without limitation, the policies, rules, and regulations of the Division.

Both parties that enter into this Contract understand that before the Contract can be executed, the Contract must be approved by the Centers for Medicare and Medicaid Services.

In the event that the Contractor requests that the Executive Director of the Division or his/her designee issue policy determinations or operating guidelines required for proper performance of the Contract, the Division shall do so in a timely manner. The Contractor shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines unless the Contractor acts negligently, maliciously, fraudulently, or in bad faith.

D. **Representatives for the Division and Contractor**

The Deputy Administrator of Health Services shall serve as the Contract Officer, representing the Executive Director of the Division of Medicaid, with full decision-making authority. All statewide policy decisions or Contract interpretation will be made through the Deputy Administrator of Health Services. The Deputy shall be responsible for the interpretation of all Federal and State laws and regulations governing or in any way affecting this Contract. The Contractor shall not interpret general Medicaid policy. When interpretations are required, the Contractor will submit written requests to the Division.

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

E. **Notices**

Whenever, under this Contract or associated RFP, one party is required to give notice to the other, except for purposes of Notice of Termination under Section 15.K, Procedure on Termination, of this Contract, such notice shall be deemed given upon delivery, if delivered by hand, or upon the date of receipt or refusal, if sent by registered or certified mail, return receipt requested or by other carriers that require signature upon receipt. Notice may be delivered by facsimile transmission, with original to follow by certified mail, return receipt requested, or by other carriers that require signature upon receipt, and shall be deemed given upon transmission and facsimile confirmation that it has been received. Notices shall be addressed as follows:

In case of notice to the Division:

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

In case of notice to the Contractor:
Contractor Designee
Contractor
Street Address
City, State Zip Code

F. **Contractor Representations**

The Contractor hereby represents and warrants to the Division that:

1. The Contractor has at least five (5) years of experience with a Medicaid program;

2. The Contractor is licensed in the State of Mississippi by the Department of Insurance; or is in the process of obtaining license in Mississippi to be effective prior to the Enrollment of beneficiaries;

3. All information and statements contained in the Mississippi Coordinated Access Network (MississippiCAN) Contract Proposal and responses to additional letter inquiries submitted by the Contractor to the Division are true and correct as of the date of this Contract;

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

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

6. The Contractor has not been sanctioned by a State or Federal government within the last ten (10) years;

7. The Contractor has experience in contractual services providing the types of services described in the RFP and this Contract; and

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

The Contractor shall have, or obtain, any license/permits that are required prior to and during the performance of work under this Contract.

G. **Assignment of the Contract**

The Contractor shall not sell, transfer, assign, or otherwise dispose of the Contract or any portion thereof or of any right, title, or interest therein without prior written consent of the Division. Any such purported assignment or transfer shall be void. If approved, any assignee shall be subject to all terms and conditions of this Contract and other supplemental contractual documents. No approval by the Division of any assignment may be deemed to obligate the Division beyond the provisions of this Contract. This provision includes reassignment of the Contract due to change in ownership of the Contractor. The Division shall at all times be entitled to assign or transfer its rights, duties, and/or obligations under this Contract to another governmental agency in the State of Mississippi upon giving prior written notice to the Contractor.

H. **Notice of Legal Action**

The Contractor shall provide written notice to the Division of any legal Action or notice listed below, within ten (10) calendar days following the date the Contractor receives notice of the following:

1. Any Action, suit or counterclaim filed against it;

2. Any regulatory Action, or proposed Action, respecting its business or operations;

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

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

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

6. The conviction of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or who is an agent or managing employee of the Contractor, any Subcontractor or supplier, of a criminal offense related to that

person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; and

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

A complete copy of all filings and other documents generated in connection with any such legal action shall be immediately provided to the Division.

I. **Ownership and Financial Disclosure**

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

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

1. Disclosures

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

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

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

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

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

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

e. The name of any other managed care entity in which an owner of the Contractor has an ownership or control interest; and

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

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

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

b. Upon the Contractor executing a contract with the State;

c. Upon renewal or extension of the Contract; and

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

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

In accordance with 42 C.F.R. § 455.104(e), Federal financial participation is not available in payments made to a Contractor that fails to disclose ownership or control information as required by said section.

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

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

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

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

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

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

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

At the time of Contract execution and Contract renewal, the Contractor must submit information for any person who has ownership and control interest of each contracted Provider entity or who is an agent or managing employee of the Provider (as defined by 42 C.F.R. § 455.101) and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs, as required in 42 C.F.R. § 455.106. The Contractor shall also make this information available to the Division upon request within thirty-five (35) calendar days. The Division may refuse to enter into or may terminate this agreement if it determines that the Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106.

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

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

a. Any director, officer, partner, employee, or assignee responsible for management or administration of the Contractor; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of

trust, note or other interest secured by, and valuing more than five percent (5%) of the Contractor; or in the case of a Contractor organized as a nonprofit corporation, an incorporator or Member of such corporation under applicable State corporation law;

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

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

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

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

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

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

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

d. A justification of the reasonableness of each transaction.

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

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

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

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

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

a. Name, address, and official position;

b. A biographical summary;

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

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

e. The identity of any person, principal, agent, managing employee, or key Provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under Medicaid or Medicare since the inception of those programs (1965) or (2) has been excluded from the Medicare and Medicaid programs for any reason. This disclosure must be in compliance with § 1128, as amended, of the Social Security Act, 42 USC §1320a-7, as amended, and 42 C.F.R. § 455.106, as amended, and must be submitted on behalf of the Contractor and any Subcontractor as well as any Provider of health care services or supplies.

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

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

2. Change of Ownership

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

The Contractor must comply with all laws of the State of Mississippi and the Mississippi Department of Insurance requirements regarding change of ownership of the Contractor.

Should the Contractor undergo a change of direct ownership, the Contractor must

notify the Division in writing prior to the effective date of the sale. The new owner must complete a new Contract with the Division and Members will be notified. Any change of ownership does not relieve the previous owner of liability under the previous Contract.

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

J. **Responsiveness to Division Requests**

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

The Contractor shall acknowledge receipt of the Division's written, electronic, or telephonic non-urgent requests for assistance no later than two (2) business days from receipt of the request from the Division. Executive request, program requests and Medicaid Investigated Grievances must be given priority by the Contractor and must be completed within the time frame requested by the Division. Such urgent requests include issues involving legislators, legislative committees (e.g., Joint Committee on Performance Evaluation and Expenditure Review), other governmental bodies, and Care Management evaluation requests involving Members or Providers requiring an *expeditious* response based on the Member's health condition.

The Contractor's acknowledgement of Division requests for assistance must include a planned date of resolution. The Contractor shall submit to the Division in the format requested, a detailed resolution summary advising the Division of the Contractor's action and resolution.

K. **Division Policies and Procedures**

The Contractor shall comply with all applicable policies and procedures of the Division, such as Mississippi Administrative Code, Title 23, specifically including without limitation all policies and procedures applicable to each category of covered services for the MississippiCAN Program, which are also covered by the State Plan, all of which are hereby incorporated into this Contract by reference and form an integral part of this Contract. In no instance may the limitations or exclusions imposed by the Contractor with respect to covered services be more stringent than those specified in the applicable laws, policies and procedures.

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

1. To the Division with its application for a Medicaid contract and whenever the Contractor adopts the policy during the term of the contract;

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

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

4. Information must be provided to Members within ninety (90) calendar days after adopting the policy with respect to any particular service and at least thirty (30) days of the effective date of the policy.

L. **Administration, Management, Facilities and Resources**

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

The Contractor shall be responsible for the administration and management of all aspects of the Contractor and the performance of all of the covenants, conditions and obligations imposed upon the Contractor pursuant to this Contract. No delegation of responsibility, whether by Subcontract or otherwise, shall terminate or limit in any way the liability of the Contractor to the Division for the full performance of this Contract.

The Contractor shall have, at a minimum, the following key management personnel or persons with comparable qualifications, as listed below, employed during the term of this Contract. All staff must be qualified by training and experience.

Executive Positions:

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

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

3. Chief Financial Officer: A professional designated to oversee financial-related functions of the Contractor.

4. Medical Director: A Mississippi licensed physician to serve as the Medical Director, who shall be responsible for all clinical decisions of the Contractor, and who shall oversee and be responsible for the proper provision of covered services to Members. The Medical Director must be an actively practicing physician located in Mississippi, unless otherwise authorized by the Division. The Medical Director shall be

responsible for overseeing functions of the Credentialing Committee and shall be required to be the Chair of the Credentialing Committee.

5. Chief Information Officer: A professional who will oversee information technology and systems to support Contractor operations, including submission of accurate and timely encounter data.

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

Administrative Positions:

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

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

3. Quality Management Director: A designated health care practitioner to oversee quality management and improvement activities.

4. Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions.

5. Complaint/Grievance Coordinator: A dedicated person for the processing and resolution of Complaints, Grievances, and Appeals.

6. Claims Administrator: A dedicated, professional to oversee claims administration.

7. Other key personnel as identified by Contractor.

The key personnel required to be located in Mississippi must be approved by the Division prior to assignment. The Division reserves the right to approve additional key positions as needed. Key management positions cannot be vacant for more than ninety (90) calendar days. The Contractor must notify the Division within five (5) business days of learning that any key position is vacant or anticipated to be vacant within the next thirty (30) calendar days.

The Division may impose penalties if any key management personnel positions remain vacant for greater than ninety (90) calendar days. The Division must approve any filled vacant positions prior to the assignment. If the position is filled without Division approval, the Division may impose penalties in accordance with Section 15, Default and Termination, of this Contract.

Prior to diverting any of the specified key personnel for any reason, the Contractor must notify the Division in writing, and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of

covered services. These changes are to be reported when individuals either leave or are added to these key positions.

The Contractor shall also have the following staff located in Mississippi, at a minimum:

1. A designated person to be responsible for data processing and the provision of accurate and timely reports and encounter data to the Division;

2. Designated staff to be responsible for ensuring that all contracted Providers, and all Non-Contracted Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations;

3. Designated staff to be responsible for Marketing or public relations;

4. Sufficient support staff to conduct daily business in an orderly manner;

5. Sufficient medical management staffing to perform all necessary medical assessments and to meet all MississippiCAN Members' Care Management needs at all times; and

6. A designee who can respond to issues involving systems and reporting, encounter data, Appeals, quality assessment, Member services, Provider services, EPSDT services management, pharmacy management, medical management, and Care Management.

M. **Base of Operations**

The Contractor shall have an Administrative Office within fifteen (15) miles of the Division of Medicaid's High Street location in Jackson, Mississippi. The office must also have space for Division staff to work and that space must include, at a minimum, the following:

1. A private office with a door that locks;

2. A desk and desk chair;

3. A computer with a printer;

4. A fax machine;

5. A phone;

6. A bookcase;

7. A file cabinet that locks;

8. Internet access; and

9. Standard office supplies.

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

N. **Cultural Competency**

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

O. **Representatives for the Division and Contractor**

At its discretion, the Division may rely on contracted Agents to perform selected activities under the direction of the Division. Some of these Agents may include but are not limited to the (1) Utilization Management Contractor, who will perform designated Prior Authorization, data analyses, and related functions and (2) the Fiscal Agent that will process CCO encounter data and provide Enrollment assistance to Members.

P. **Risk Management**

The Contractor may 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 withholding of payment by the Division, or imposition of penalties by the Division.

On or before beginning performance under this Contract, the Contractor shall obtain from an insurance company, duly authorized to do business and doing business in Mississippi, insurance as follows:

1. Workers' Compensation

   The Contractor shall obtain, purchase and maintain, during the life of this Contract, workers' compensation insurance for all employees employed under the Contract in Mississippi. Such insurance shall fully comply with the Mississippi Workers' Compensation Law. In case any class of employees engaged in hazardous work under this Contract at the site of the project is not protected under the Workers' Compensation Statute, the Contractor shall provide adequate insurance satisfactory for protection of his or her employees not otherwise protected.

2. Liability

   The Contractor shall ensure that professional staff and other decision making staff shall be required to carry professional liability insurance in an amount commensurate with the professional responsibilities and liabilities under the terms of this Contract and other supplemental contractual documents.

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

SECTION 2 – DEFINITIONS

A. Definitions

1. **Action:** The Contractor's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or the Contractor's failure to provide services in a timely manner; failure to resolve Complaints, Grievances, or Appeals within the time frames specified in this contract.

2. **Agent:** An authorized entity that acts on behalf of the Division of Medicaid.

3. **Appeal:** A request for review by the Contractor of a Contractor Action related to a Member or Provider. In the case of a Member, the Contractor Action may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member). In the case of a Provider, the Contractor Action may include, but is not limited to, delay or non-payment for covered services.

4. **Auto Enrollment of Members:** The process by which Members who have not voluntarily selected a CCO are assigned to a CCO.

5. **Behavioral Health Services:** Mental health and/or drug and alcohol abuse treatment services that are provided by the county mental health/mental retardation programs, the single county authority administrators, or other appropriately licensed health care practitioners.

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

7. **Capitation Payments:** Actuarially determined, per Member per month rates paid to the Contractor for the provision of all covered services to enrolled Members.

8. **Closed Panel:** Providers who are no longer accepting new patients for the Contractor as part of the MississippiCAN Program have a Closed Panel.

9. **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

10. **Contractor:** Per 42 C.F.R. Part 438, a managed care Contractor providing services through various delivery systems may be a Managed Care Organization (MCO) as authorized under 1932(a)(1)(A) of the Social Security Act.

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

12. **Deliverables:** Those documents, records and reports required to be furnished to the Division for review and/or approval pursuant to the terms of the RFP and this Contract.

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

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

15. **Division:** The Division of Medicaid, Office of the Governor, State of Mississippi.

16. **Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services:** Defined by the Division to include:

    a. Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;

    b. Calculation of Body Mass Index;

    c. Growth measurements and head circumference;

    d. Nutritional counseling;

    e. Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;

    f. Comprehensive unclothed exam;

    g. Appropriate laboratory tests (including blood level assessment appropriate to age and risk);

    h. Appropriate immunizations in accordance with Recommended Childhood and

Adolescent Immunization Schedule adopted by the Division;

i. A vision assessment;

j. A hearing assessment;

k. A dental screening and/or referral to dental care;

l. Health education; and

m. Referrals for identified abnormalities.

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

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

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

20. **Expedited Resolution:** An expedited review by the Contractor of a Contractor Action.

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

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

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

24. **Fraud and Abuse:** Fraud is any type of intentional deception or misrepresentation

made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including the vendor, a Subcontractor, a Provider, a State employee, or a Member, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, the vendor, a Subcontractor or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

25. **Grievance:** An expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor Action as defined in this contract.

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

27. **Marketing:** The activities that promote visibility and awareness for the MississippiCAN Program and the CCOs participating in the program. All activities are subject to prior review and approval by the Division.

28. **Maternity "Kick" Payment:** A case rate payment to the CCO for hospital inpatient physician maternity delivery services. The Maternity "Kick" Payment will be paid to the CCO when the Division determines a Member delivers a live baby or stillborn baby. The Maternity "Kick" Payment is paid to the CCO in addition to the monthly full risk, prepaid capitation rate.

29. **Medicaid Investigated Grievance:** A written Member or Provider Grievance to the Director of the Division of Medicaid (or to another State agency or official and which is directed to the Division) where (a) Division staff are assigned to investigate and address the issues raised by the Complaint, and (b) the Division concludes that the Complaint is valid even if the disposition of the Complaint is not resolved in favor of the complaining party. These grievances consist of complaints or disputes expressing dissatisfaction with any aspect of the operations, activities, or behavior of the Contractor, or its Providers, regardless of whether remedial action is requested.

30. **Medical Home:** A health care setting that facilitates partnerships between individual patients, their Primary Care Providers, and when appropriate, the patient's family to provide comprehensive primary care.

31. **Medical Loss Ratio (MLR):** The proportion of premium revenues spent on clinical services and quality improvement by the CCO.

32. **Medical Loss Ratio Reporting (MLR) Year:** State fiscal year (e.g., July 1 through June 30) during which benefits and services are provided to Members through contract with the Division.

33. **Medical Record:** A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or Non-Contracted Providers.

34. **Medically Necessary Services:** As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

    a. Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;

    b. In accordance with the standards of good medical practice consistent with the individual patient's condition(s);

    c. Not primarily for the personal comfort or convenience of the Member, family, or Provider;

    d. The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;

    e. Furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;

    f. Not experimental or investigational or for research or education;

    g. Provided by an appropriately licensed practitioner; and

    h. Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

    Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

35. **Member:** An individual who meets all of the eligibility requirements for Mississippi Medicaid and enrolls in a CCO under the MississippiCAN Program.

36. **Mississippi Coordinated Access Network (MississippiCAN) Program:** Mississippi Medicaid's coordinated care program for eligible Members that enroll

within a CCO, which are reimbursed with actuarially sound prepaid Capitation Payment rates.

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

38. **Non-Contracted Provider:** A health care Provider who has not been credentialed by and does not have a signed Provider agreement with the Contractor.

39. **Non-Emergency Transportation:** Transportation for Members to receive medical services on a non-emergency basis.

40. **Open Panel:** Providers who are accepting new patients for the Contractor as part of the MississippiCAN Program.

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

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

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

44. **Pharmacy Benefit Manager (PBM):** A business that administers the prescription drug portion of covered services on behalf of the Contractor and/or the Division, in accordance with Miss. Code Ann. § 73-21-179.

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

46. **Preferred Drug List (PDL):** A medication list recommended to the Division of Medicaid by the Pharmacy & Therapeutics Committee and approved by the Executive Director of the Division of Medicaid for use in the Fee-for-Service delivery system and the MississippiCAN Program. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. The Contractor is required to follow the guidance provided in the PDL.

47. **Primary Care Provider (PCP):** Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of

medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

48. **Prior Authorization:** A determination to approve a Provider's request, pursuant to services covered in the MississippiCAN Program, to provide a service or course of treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

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

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

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

52. **Reinsurance:** Private insurance purchased by the Contractor to protect against individual high cost cases and/or aggregate high cost. Insurance purchased by the Contractor from insurance companies to protect against part of the costs of providing covered services to Members.

53. **Reserve Account:** An account established pursuant to Section 12.A, Capitation Payments, of this Contract into which a portion of the payments made by the Division are deposited and held as security for any refund or liquidated damages due the Division.

54. **Rural Health Clinics:** The Rural Health Clinics (RHCs) program is intended to increase primary care services for Medicaid and Medicare patients in rural communities. RHCs can be public, private, or non-profit. RHCs receive enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must be located in rural, underserved areas and must use midlevel practitioners.

55. **State Fair Hearing:** A hearing conducted by the Division of Medicaid or its Agent in accordance with 42 C.F.R. § 431 Subpart E.

56. **State Medicaid Fraud Control Unit:** A Unit of the Mississippi Attorney General's office. This Unit has the mission of investigating and prosecuting criminal cases of Fraud in the Mississippi Medicaid program.

57. **Subcontract:** An agreement between the Contractor and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of the Contractor's responsibilities under this Contract. Subcontracts must be

approved in writing by the Division prior to the start date of the agreement.

58. **Subcontractor:** An entity with which the Contractor enters into an agreement to provide contractually required services.

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

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

61. **Urgent Care:** Services that are urgently needed and the failure to provide them promptly or to continue them may cause deterioration or impair improvement in condition, including but not limited to: inpatient services, home health care, pharmaceuticals, therapy services, or surgery.

B. **Acronyms**

1. ABN – Advance Beneficiary Notification
2. ACIP – Advisory Committee on Immunization Practices
3. CAHPS® – Consumer Assessment of Healthcare Providers and Systems
4. CAP – Corrective Action Plan
5. CCO – Coordinated Care Organization
6. CEO – Chief Executive Officer
7. CLIA – Clinical Laboratory Improvement Amendments
8. CMS – Centers for Medicare and Medicaid Services
9. COE – Category of Eligibility
10. CST – Central Standard Time
11. DHHS – Department of Health and Human Services
12. DOM – Division of Medicaid
13. DOI – Department of Insurance
14. EHR – Electronic Health Record

15. EPSDT – Early, Periodic, Screening, Diagnosis, and Treatment

16. EQRO – External Quality Review Organization

17. FQHC – Federally Qualified Health Center

18. GAAP – Generally Accepted Accounting Principles

19. HEDIS® – Healthcare Effectiveness Data and Information Set

20. HHS – United States Department of Health and Human Services

21. HIPAA – Health Insurance Portability and Accountability Act

22. MDHS – Mississippi Department of Human Services

23. MEPA – Mississippi Employment Protection Act

24. MES – Medicaid Enterprise System

25. MLR – Medical Loss Ratio

26. MMIS – Medicaid Management Information System

27. MS HIN – Mississippi Health Information Network

28. MSCAN – Mississippi Coordinated Access Network (MississippiCAN)

29. MSDH – Mississippi State Department of Health

30. NAIC – National Association of Insurance Commissioners

31. NET – Non-Emergency Transportation

32. NCQA – National Committee for Quality Assurance

33. NPI – National Provider Identifier

34. OIG – Office of Inspector General

35. PBM – Pharmacy Benefits Manager

36. PCP – Primary Care Provider

37. PDL – Preferred Drug List

38. PHRM/ISS – Perinatal High Risk Management/Infant Services System

39. PHI – Protected Health Information

40. PI – Program Integrity

41. PII – Personal Identification Information

42. PIP – Performance Improvement Project

43. PMPM – Per Member Per Month

44. QI – Quality Improvement

45. QM – Quality Management

46. RHC – Rural Health Clinic

47. TANF – Temporary Assistance for Needy Families

48. TPL – Third Party Liability

49. TTY/TTD – Text Telephones/Telecommunications Device for the Deaf

SECTION 3 – MEMBER ELIGIBILITY

A. General Requirements

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

The Program will operate on a statewide basis. The Program will include both (1) Members who have the option to disenroll and receive services through the Fee-for-Service delivery system, and (2) Members who may not disenroll depending on Member's category of eligibility. The Division reserves the right to assign a Member to a specific health plan.

B. Populations That Have the Option to Enroll in the MississippiCAN Program

Table 1 specifies Medicaid populations that may voluntarily enroll in MississippiCAN. The Division will enroll eligible Members within these categories into MississippiCAN, and beneficiaries will have the option to disenroll once within ninety (90) days of initial enrollment. Members that disenroll will be served through the Medicaid fee-for-service system.

Table 1. Populations Who Have the Option to Enroll

Populations Who Have the Option to Enroll	Age Categories
SSI	0-19

Populations Who Have the Option to Enroll	Age Categories
Disabled Child Living at Home	0-19
DHS-Foster Care Children	0-19
DHS-Foster Care Children (Adoption Assistance)	0-19
Native Americans	0-65

C. **Population That May Not Disenroll from the MississippiCAN Program**

Table 2 specifies Medicaid populations that the Division will enroll into MississippiCAN Program on a mandatory basis. These beneficiaries may voluntarily select or be automatically enrolled with a CCO, but may not opt out of the MississippiCAN Program. Members may change CCO selection once within the first ninety (90) days of enrollment and thereafter during open enrollment periods.

Table 2. Population Who May Not Disenroll

Population Who May Not Disenroll	Age Categories
SSI	19-65
Working Disabled	19-65
Breast and Cervical Cancer	19-65
Pregnant Women	8-65
Parent/Caretakers-TANF	19-65
Newborns (Populations other than those listed in Table 1)	0-1

D. **Coordination with the Division or its Agent**

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

SECTION 4 – ENROLLMENT AND DISENROLLMENT

The Division or its Agent shall send written notification to the Member to inform the Member of Enrollment into the MississippiCAN Program and to select a CCO and PCP.

A. **Enrollment of Members with a CCO**

A Member shall have thirty (30) Calendar Days to select a CCO and a PCP. Members who fail to make a voluntary Contractor selection within thirty (30) calendar days of their Enrollment will be auto enrolled to a Contractor by the Division. Auto-assignment rules will include provisions to:

1. Determine whether the Member was previously enrolled within a CCO with the previous sixty (60) calendar days; and assign member to that CCO;

2. Determine whether an immediate family member is assigned to a CCO and assign the Member to that CCO;

3. Review paid claims data within the past six (6) months and assign Member to the CCO that has a contract with a PCP with whom the Member has a history in the last six (6) months; and

4. If no previous assignment within sixty (60) days; and no immediate family members already enrolled, of if the Member does not have a prior history with a PCP, then assign the Member to Contractor with a PCP closest to Member's home address.

5. If multiple Contractors meet this standard, then assignment will occur using a random process.

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

The Division may, at its discretion, set and make subsequent changes to a threshold for the percentage of Members who can be enrolled with a single CCO. Members will not be auto enrolled to a CCO that exceeds this threshold unless a family member is enrolled in the CCO or a historical Provider relationship exists with a Provider that does not participate in any other CCO. The Division will provide the CCOs with a minimum of fourteen (14) days advance notice in writing when changing the threshold percentage.

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

B. **Choice of a Health Care Professional**

The Contractor shall offer each Member the opportunity to choose from at least two (2) network primary care Providers (PCPs). If the Member does not voluntarily choose a

PCP, the Contractor may assign the Member a PCP. A Member who has received Prior Authorization from the Contractor for referral to a specialist or from the Division's vendor for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's network to the extent possible, reasonable, and appropriate.

The Contractor is responsible for assigning Members to PCPs to serve as Medical Homes and must have written policies and procedures for assigning Members to PCPs. The Contractor must submit PCP assignment policies and procedures to the Division for review and approval upon contract award and must also submit any significant updates. Any changes or modifications to these policies and procedures must be submitted by the Contractor to the Division at least thirty (30) calendar days prior to implementation and must be approved by the Division.

These policies and procedures shall include the features listed below:

1. Providers Qualifying as Primary Care Providers (PCP): The following types of specialty Providers may perform as Primary Care Providers:

    a. Pediatricians;

    b. Family and General Practitioners;

    c. Internists;

    d. Obstetrician/Gynecologists;

    e. Nurse Practitioners (contracted nurse practitioners acting as PCPs must have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at an inpatient hospital facility);

    f. Physician Assistants;

    g. Specialists who perform primary care functions upon request (e.g., surgeons, clinics, including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics); or

    h. Other Providers approved by the Division.

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

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

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

C. **Enrollment Period**

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

The Division shall provide Members with continuous open enrollment periods. The first ninety (90) days following Enrollment will be an open enrollment period during which they can enroll once with a different Contractor without cause. Members subject to Enrollment of both populations are subject to the following requirements:

1. **Enrollment of Populations with the Option to Disenroll:** The Division will enroll newly eligible Medicaid beneficiaries into MississippiCAN. Beneficiaries who are in eligibility categories that may voluntarily participate in MississippiCAN will have the option to disenroll from the MississippiCAN Program without cause or change Contractors without cause during this ninety (90) day period following the date the Division sends the Member notice of Enrollment or the date of the Member's initial Enrollment, whichever is later; during the annual open Enrollment period; upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity; or when the Division imposes an intermediate sanction on the Contractor as specified in this Contract in Section 15, Default and Termination, of this Contract.

2. **Enrollment of Populations Who May Not Disenroll:** Members who are mandated into the Program may change CCOs without cause during this ninety (90) day open enrollment period. Following the ninety (90) day open enrollment period, these Members will be locked into that Contractor until the next open enrollment period that will occur at least once every twelve (12) months.

The Division or its Agent will notify Members at least once every twelve (12) months, and at least sixty (60) Calendar Days prior to the date upon which the Enrollment period ends that they have the opportunity to switch CCOs or to change their program selection if the Member has the option to disenroll from MississippiCAN. Members who do not

make a choice will be deemed to have chosen to remain with their current CCO.

D. **Contractor Member Information Packet**

The Contractor shall provide each Member, prior to the first day of the month in which their Enrollment starts, an information packet indicating the Member's first effective date of Enrollment. The Contractor must ensure the information is provided no later than fourteen (14) Calendar Days after the Contractor receives notice of the Member's Enrollment. The Contractor shall utilize at least first class or priority mail delivery services as the medium for providing the Member identification cards. The Division must receive a copy of this packet on an annual basis for review and approval, or at any point when changes are made to the packet. At a minimum, the Member information packet shall include:

1. An introduction letter;

2. A MississippiCAN Program identification card;

3. Information about how to obtain a copy of a Provider Directory in compliance with 42 CFR § 438.10(f)(6) at a minimum; and

4. A Member Handbook.

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

E. **Health Risk Screening**

The Contractor shall complete a brief five (5) question Health Risk Screening for all Members to identify Members who may require assignment into medium or high risk levels for Care Management. The Health risk Screening may be conducted via telephone, via mail, or via email, if the Member designates an email address and chooses for communication. Communications with Members must be clear and understandable. The Contractor shall complete the Health Risk Screening within the following time frame s:

1. Within ninety (90) Calendar Days for all Members upon contract implementation; and

2. Within thirty (30) calendar days from the effective date of Enrollment for newly enrolled Members after contract implementation.

Please refer to Section 8, Care Management, of this Contract for additional requirements related to Care Management.

F. **Enrollment Verification**

The Division, or its agent, shall provide the Contractor on a monthly basis a listing of all MississippiCAN Program Members who have selected or been assigned to the Contractor.

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

G. **Disenrollment**

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

1. No longer resides in the State of Mississippi;

2. Is deceased;

3. No longer qualifies for medical assistance under one of the Medicaid eligibility categories in the eligible population; or

4. Becomes a nursing home resident

5. Becomes institutionalized or enrolled in a waiver program

6. Becomes eligible for Medicare coverage; or

7. Is diagnosed with hemophilia.

The Contractor may request Disenrollment of a Member at any time based upon one or more of the reasons listed herein. The Contractor must notify the Division within three (3) calendar days of receipt of the Member Listing Report of their request that a Member be disenrolled and provide written documentation of the reason for the Disenrollment request. The Division will make a final determination regarding Disenrollment. Approved Disenrollment shall be effective on the first (1st) day of the calendar month for which the Disenrollment appears on the Member Listing Report.

The Contractor must file a request to disenroll a Member with the Division in writing stating specifically the reasons for the request if the reasons differ from those specified above.

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

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

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

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

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

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

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

The effective date of any approved Disenrollment will be no later than the first (1st) day of the second (2nd) month following the month in which the Member or the Contractor files the request with the Division.

H. **Disenrollment of Nursing Home Residents**

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

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

I. **Disenrollment of Medicare Recipients**

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

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

J. **Re-Enrollment and Retroactive Eligibility**

The Division or its Agent will automatically re-assign a Member into the CCO in which he or she was most recently assigned if the Member has a temporary loss of eligibility, defined as less than sixty (60) Calendar Days.

The Division will only retroactively enroll newborns in category of eligibility 088-

pregnant women and infants.

K. **Member Listing Report**

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

The Member Listing Report shall be provided to the Contractor sufficiently in advance of the Member's Enrollment effective date to permit the Contractor to fulfill its identification card issuance and PCP notification responsibilities, described in Sections 6.C, Member Identification Card, and 4.B, Choice of a Health Care Professional, of this Contract, respectively. Should the Member Listing Report be delayed in its delivery to the Contractor, the applicable time frame s for identification card issuance and PCP notification shall be extended by one (1) business day for each day the Member Listing Report is delayed. The Division and the Contractor shall reconcile each Member Listing Report as expeditiously as is feasible but no later than the twentieth (20th) day of each month.

L. **Enrollment of Children in Foster Care**

If the Contractor is responsible for the provision of services to children in foster care, the Contractor shall comply with relevant Mississippi Department of Human Services and Division policies related to this population and associated state and federal requirements.

M. **Enrollment Discrimination**

Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services or on the basis of race, color, age, religion, sex, national origin, limited English proficiency, marital status, political affiliation, or level of income and shall not use any policy or practice that has the effect of discrimination on the basis of race, color, national origin, limited English proficiency, marital status, political affiliation, or level of income.

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

The Division may impose penalties in accordance with Section 15, Default and

Termination, of this Contract if the Contractor is in violation of this section.

SECTION 5 – COVERED SERVICES AND BENEFITS

The Contractor must ensure that all services provided are Medically Necessary. The Contractor must submit reports related to covered services and benefits in accordance with Section 10, Reporting Requirements, and Exhibit H, Reporting Requirements, of this Contract.

A. **Covered Services**

The Contractor shall provide all Medically Necessary covered services allowed under the MississippiCAN Program. The Contractor shall ensure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled beneficiaries in the Fee-for-Service delivery system; and that no incentive is provided, monetary or otherwise, to Providers for withholding from Members' Medically Necessary Services. The Contractor shall make available accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this Contract.

B. **Emergency Services**

The Contractor shall cover and pay for emergency medical services regardless of whether the Provider that furnishes the services has a contract with the Contractor.

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

1. A Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes of placing the health of the individual (or pregnant woman and unborn child) in serious jeopardy, or would not have resulted in serious impairment to bodily functions, or would not result in serious dysfunction of any bodily part.

2. The Contractor instructed the Member to seek emergency services.

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

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

C. **Post-Stabilization Care Services**

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

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

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

2. The Contractor cannot be contacted; or

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

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

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

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

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

4. The Member is discharged.

D. **EPSDT Services**

The Contractor shall comply with Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and Federal regulations at 42 C.F.R. Part 441 Subpart B that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services.

The Contractor must have written policies and procedures related to the provision of the full range of EPSDT services as defined in, and in accordance with, the Division's policies and procedures for EPSDT and the provisions of this Contract. Such services shall include, without limitation, periodic health screenings and appropriate and up-to-date immunizations using the ACIP Recommended Immunization Schedule of all

Members age one (1) or under one (1), in accordance with the Periodicity Schedule established for EPSDT services, including periodic examinations for vision, dental, and hearing and all medically necessary services. The Contractor shall identify all Members age one (1) or under one (1) whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations.

The Division requires that the Contractor cooperate to the maximum extent possible with efforts to improve the health status of Mississippi citizens, and to actively work to improve the percentage of Members receiving appropriate screenings, and meet or exceed the percentage of screenings for the Medicaid Fee-for-Service population.

The following minimum elements must be included in the Periodic Health Screening Assessment:

1. Comprehensive health and development history (including assessment of both physical and mental development);

2. Measurements (including head circumference for infants);

3. Comprehensive unclothed physical examination;

4. Immunizations appropriate to age and health history;

5. Assessment of nutritional status;

6. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

7. Vision screening;

8. Hearing screening;

9. Dental and oral health assessment;

10. Developmental assessment; and

11. Health education and anticipatory guidance.

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

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

1. Initial visit for newborns;

2. EPSDT screenings and reporting of all screening results; and

3. Diagnosis and/or treatment for children.

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

1. Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Members;

2. Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period;

3. If requested, any necessary assistance with arranging for transportation to ensure that Members obtain necessary EPSDT screening services. This assistance must be offered prior to each due date of a child's periodic examination;

4. Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate;

5. A process for outreach and follow-up to Members under the age of twenty-one (21) with special health care needs; and

6. For children in foster care only, a process for outreach and follow-up with County Department of Human Services Agencies to assure that they are notified of all Members under the age of twenty-one (21) who are under their supervision and who are due to receive EPSDT screens and follow-up treatment.

The Contractor may develop alternate processes for follow-up and outreach subject to prior written approval from the Division.

E. **Behavioral Health**

The Contractor shall provide Behavioral Health Services to Members in the MississippiCAN Program. The Contractor shall comply with all requirements related to Care Management, access and availability with respect to Behavioral Health Services. All Behavioral Health Services covered by Medicaid that are medically necessary must be covered.

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

Division policy regarding Behavioral Health Services is referenced in the Mississippi Administrative Code, Title 23, Part 206, but other sections of the code may also be referenced.

F. **Prescription Drug Services**

The Contractor shall provide pharmacy services to Members enrolled in the MississippiCAN Program. The Contractor shall comply with the Mississippi Pharmacy

Practice Act and the Mississippi Board of Pharmacy rules and regulations.

The Contractor is restricted from requiring Members to utilize a pharmacy that ships, mails, or delivers prescription drugs or devices. However, the Contractor may implement a mail-order pharmacy program in accordance with State and Federal law.

The Contractor must use the most current version of the Medicaid Program Preferred Drug List (PDL), which is subject to periodic changes. The Contractor must use the Medicaid PDL developed by the Division or its Agent and may not develop and use its own PDL. The Contractor will be provided opportunities to offer feedback on the PDL to the Pharmacy and Therapeutics Committee, which is an advisory panel that conducts in-depth clinical evaluations and recommends appropriate drugs for preferred status on the PDL and/or drugs for Prior Authorization. The Executive Director of the Division has final authority on drugs with preferred status on the PDL and/or drugs for Prior Authorization.

Refer to the Pharmacy Services page on the Division's website for a current listing of prescription drugs on the PDL to ensure continuity of care for Members.

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

The Contractor shall ensure that prescription drugs are prescribed and dispensed in accordance with medically accepted indications for uses and dosages. No payment may be made for services, procedures, supplies or drugs which are still in clinical trials and/or investigative or experimental in nature. The Contractor may consider exceptions to the criteria if there is sufficient documentation of stable therapy as reflected in ninety (90) calendar days of paid Medicaid claims.

The Contractor is not authorized to negotiate rebates with drug companies for preferred pharmaceutical products. The Division or its Agent will negotiate rebate agreements. If the Contractor or its Subcontractor has an existing rebate agreement with a manufacturer, all Medicaid outpatient drug claims, including Provider-administered drugs, must be exempt from such rebate agreements.

Please refer to Mississippi Administrative Code, Title 23, Part 203. The Contractor shall report information specified by the Division to enable the collection of rebates by the Division, as described in Section 10, Reporting Requirements, of this Contract. The Division processes Prior Authorization requests for prescription drugs within twenty-four (24) hours of receiving the request. The Contractor shall adhere to this time frame.

G. **Non-Emergency Transportation**

The Contractor shall provide Non-Emergency Transportation for its Members to access Medically Necessary Services, in compliance with minimum Federal requirements for the provision of transportation services and according to Division policies, which are

outlined in Mississippi Administrative Code, Title 23, Part 201. Non-Emergency Transportation shall be provided to Members who require transportation to and from Medicaid covered non-emergency services.

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

H. **Non-Covered Services**

1. The Contractor is not responsible for coverage of inpatient hospital facility services. However, the Contractor is responsible for coverage of services billed by physicians and other Providers during a hospital stay (including, but not limited to, physician surgeries, inpatient physician visits). Should the Division decide to include inpatient hospital services within the MississippiCAN Program, the Contract would be amended.

   The Contractor is not responsible for Prior Authorization for inpatient hospital services. The Division has an existing contract with a Utilization Management Contractor from which Providers must request Prior Authorization of inpatient hospital facility services. Should the Division require the Contractor to conduct Prior Authorization certifications for inpatient services, the contract would be amended.

   The Contractor must coordinate inpatient services, as appropriate, with Fee-for-Service hospital Providers. The Contractor will also coordinate Care Management for Members post-hospitalization, as described in Section 8, Care Management, of this Contract.

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

I. **Enhanced Services**

The Contractor may provide enhanced services that exceed the benefits or services provided under the Mississippi Fee-for-Service delivery system, subject to advance written approval by the Division. Enhanced services are generally considered to have a direct relationship to the maintenance or enhancement of a Member's health status. Examples of potentially approvable services include various seminars and educational programs promoting healthy living or illness prevention, memberships in health clubs and/or facilities promoting physical fitness and expanded eyeglass or eye care benefits. These services must be generally available to all Members, and may not be tied to specific Member performance without Division prior approval. The Division may grant exceptions in areas where it believes that such tie-ins shall produce significant health

improvements for Members.

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

If the Contractor elects to provide enhanced services, it shall submit a statement annually as to the value of these services within thirty (30) calendar days of request from the Division or its Agent in a format to be specified by the Division.

J. **Prior Authorizations**

1. General Requirements

The Contractor must have written policies and procedures for the Prior Authorization of services, which must comply with this Contract. Prior Authorization criteria and associated policies and procedures must receive advance written approval from the Division.

The Contractor shall have procedures for processing requests for initial and continuing authorizations of services. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a physician pursuant to 42 C.F.R. § 438.210(b)(3) and Mississippi Code Ann. § 41-83-31.

The Contractor shall use a mechanism to ensure consistent application of review criteria for authorization decisions that includes consultation with the requesting Provider when appropriate.

The Contractor may not require Prior Authorization for physician or practitioner services provided in inpatient hospitals that are delivered as part of an inpatient hospital stay.

The Contractor may not structure compensation to individuals or utilization management entities so as to provide inappropriate incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Member.

The Contractor shall comply with 42 C.F.R § 438.210 (b) (3) which requires that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's

condition or disease.

2. Pharmacy

The Contractor must establish policies and procedures to comply with the Division's Prior Authorization criteria in accordance with the PDL guidance for the drugs listed on the PDL. The Contractor may approve drugs outside of the PDL when one of the following Prior Authorization criteria is satisfied:

a. Member must have used the preferred agents for at least a thirty (30) calendar day course of treatment per drug and failed trials within six (6) months prior to requesting the Prior Authorization and there is documentation of therapeutic failure of preferred drugs; or

b. Adverse event(s) reaction(s) to preferred medications; or

c. Contraindications to preferred medications (i.e. drug interaction, existing medical condition preventing the use of preferred medications).

The Contractor must establish criteria and coverage policies for drugs not listed on the PDL, which must be approved by the Division. The Contractor must ensure that decisions regarding policies and procedures for administration of prescription drugs are made in a clinically sound manner.

3. Web-based Prior Authorization System

The Contractor shall have the capability and established procedures to receive Prior Authorization requests and supporting information via secure web-based submissions and facsimile from Providers.

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

The Contractor shall have the ability to communicate through the MS HIN Health Information Exchange in the future.

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

The Contractor shall include in the Web-based, electronic review request system the ability for users to view and securely download all data, analytics, or reports that are

specific to the user defined by the user's profile and security access.

The Contractor's Web-based, electronic review request system shall have the ability to receive Prior Authorization requests from Providers using a Health Insurance Portability and Accountability Act (HIPAA) 278 Transaction, for the services where electronic submission is required. The Contractor shall have the capability to assign a unique tracking number to each review record. The Contractor's Web-based, electronic review request system shall have the ability to send and receive HIPAA-compliant PII and PHI transactions for Prior Authorization requests requiring attachments.

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

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

4. Time Frames

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

The Contractor must make standard authorization decisions and provide notice within three (3) calendar days and/or two (2) business days per Minimum Standards for Utilization Review Agents issued by the MSDH following receipt of the request for services. This three (3) calendar day period may be extended up to fourteen (14) additional calendar days upon request of the Member or the Provider to the Contractor, or if the Contractor justifies to the Division a need for additional information and how the extension is in the Member's best interest.

The Contractor must expedite authorization for services when the Provider indicates or the Contractor determines that following the standard authorization decision time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. The Contractor must provide decision notice no later than twenty-four (24) hours after receipt of the expedited authorization request. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the Member, Provider or the Contractor. The Contractor must justify to the Division a need for additional information and how the extension is in the Member's best interest.

K. **Advance Directives**

The Contractor shall develop, document, and maintain advance directive policies that comply with 42 C.F.R. § 422.128 and with the State's Uniform Health Care Decisions Act. The Contractor shall provide adult Members with written information on its advance directives policies. The Contractor shall inform the Members as to the implementation of those rights according to State law. Any written information provided by the Contractor must reflect changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of change. The Contractor must also inform Members that Complaints and Grievances concerning non-compliance with the advance directive requirements may be filed with the State Survey and Certification Division of the State Department of Health.

L. **Member Notification**

The Contractor shall mail written notice to Members of the opportunity for a State Fair Hearing in the event of the termination, suspension, or reduction of previously authorized Medicaid-covered services within ten (10) calendar days of the date of the Action for previously authorized services as permitted under 42 C.F.R. Part 431 Subpart E.

Denials of Claims that may result in Member financial liability require immediate notification. All Member communications shall meet the requirements of Section 6.F, Communication Standards, of this Contract.

M. **Services for Foster Care Children**

The Contractor will coordinate closely with the Mississippi Department of Human Services and the Division through regular meetings of a task force. The Contractor shall comply with relevant Contract requirements that impact the provision of services. The Contractor shall also provide data and reports required by the Mississippi Department of Human Services and the Division to demonstrate compliance.

SECTION 6 – MEMBER SERVICES

The Contractor must submit reports related to Member Services in accordance with Section 10, Reporting Requirements, and Exhibit H, Reporting Requirements, of this Contract.

A. Member Services Call Center

The Contractor must maintain and staff a toll-free dedicated Member services call center to respond to Members' inquiries, issues, or referrals. Members will be provided with one (1) toll free number, and the Contractor's automated system and call center staff will route calls as required to meet Members' needs.

1. Hours of Operation

The Contractor's Member services call center must operate at a minimum during

regular business hours (8:00 a.m. to 5:00 p.m. CST., Monday through Friday) and one (1) evening per week (5:00 p.m. to 8:00 p.m. CST) and one (1) weekend per month with the exception of Mississippi State holidays to address non-emergency problems encountered by Members. The Contractor must also operate a nurse advice line to receive, identify, and resolve in a timely manner emergency Member issues on a twenty-four (24) hour, seven (7) day-a-week basis.

In the case of Behavioral Health Services, Members shall have access twenty-four (24) hours, seven (7) days per week to clinical personnel who act within the scope of their licensure to practice a behavioral health-related profession.

2. Functions

The Contractor's Member services functions must include, but are not limited to, the following Member services standards:

a. Explaining the operation of the Contractor and assisting Members in the selection of a PCP;

b. Assisting Members with making appointments and obtaining services;

c. Assisting with arranging transportation for Members;

d. Referring Members to the Fraud and Abuse Hotline; and

e. Receiving, identifying and making appropriate referrals to assist Members in resolving emergency Member issues.

3. Customer Care

The Contractor must develop appropriate, interactive scripts for call center staff to use during initial welcome calls when making outbound calls to new Members and to respond to Member calls, which are subject to Division approval prior to use. The Contractor's call center staff must also use a Division-approved script to respond to Members who call to request assistance with PCP selection. The Contractor must develop special scripts for emergency and unusual situations, as requested by the Division. All scripts must be clear and easily understood. The Contractor must review the scripts annually to determine any necessary revisions. The Division reserves the right to request and review call center scripts at any time.

Under no circumstances will unlicensed Member services staff provide health-related advice to Members requesting clinical information. In such cases, these calls must be immediately transferred to clinical personnel during regular business hours, as defined above. The Contractor must ensure that all such inquiries are addressed by clinical personnel acting within the scope of their licensure to practice a health-related profession.

The Contractor's internal staff is required to ask the callers whether they are satisfied

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

The Contractor is not permitted to utilize electronic call answering methods, as a substitute for staff persons, to perform this service after business hours.

The Contractor shall randomly select and record calls received at the call center and monitor no less than three percent (3%) of calls for compliance with customer care guidelines. The Contractor will report the findings of these audits to the Division via a quarterly Deliverable report. The Contractor will make recordings available to the Division upon request within five (5) business days. The Contractor shall maintain the recordings for at least twelve (12) months.

4. Staff Training

The Contractor's Member services call center staff must receive trainings at least quarterly. Trainings must include education about Medicaid, the MississippiCAN Program, appropriate instances for transferring a Member to a Care Manager, and customer service. Staff must receive updates about continued Medicaid changes and requirements, including "Late Breaking News" articles, Provider bulletins, and MississippiCAN Program updates. The Contractor will submit quarterly reports detailing the trainings conducted, topics covered, and the number and positions of staff completing the trainings.

5. Performance

The Contractor shall maintain sufficient equipment and call center staff to ensure that the abandonment rate for any month is not greater than five percent (5%). The Contractor will be subject to sanctions if the abandonment rate exceeds this target, in accordance with Section 15, Default and Termination, of this Contract.

B. Member Education

The Contractor must implement, monitor, and evaluate a program to promote health education for its new and continuing Members. The Contractor shall maintain an annual health education and prevention work plan, based on the needs of its Members, and shall submit this work plan, with quarterly updates, to the Division for approval.

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

The Contractor shall also conduct, in collaboration with the Division, a minimum of ten (10) MississippiCAN Workshops annually targeting Members. The Division will notify the Contractor of the dates, times, and locations for Workshops. The Division will determine the topics to be covered during each workshop and the Contractor shall assist in the presentation of the content.

C. Member Identification Card

The Contractor shall provide each Member an identification card that is recognizable and acceptable to the Contractor's network Providers. The Contractor may only issue one (1) identification card for all covered benefits. The Contractor's identification card will include, at a minimum, the name of the Member, the Mississippi Medicaid identification number, the name and address of the Contractor, the name of the Member's PCP, if PCP name available, a telephone number to be used to access after-hours non-emergency care, instructions on what to do in an emergency, the Member Services Call Center phone number, and a Contractor identification number, if applicable. The Contractor must submit and receive approval of the identification card from the Division prior to production of the cards.

The Contractor shall provide each Member an identification card, prior to the first day of the month in which their Enrollment starts. The Contractor must mail all Member identification cards, utilizing at least first class or priority mail delivery services, in envelopes marked with the phrase "Return Services Requested."

On a monthly basis, the Contractor shall provide the Division the date and the number of identification cards mailed to new Members each month.

In cases of returned Member identification cards, the Contractor must attempt to contact the Member to verify the Member's address. The Contractor shall be innovative and employ creative techniques to contact Members with returned Member identification cards and identify valid addresses for these Members.

D. Member Handbook

After the Contractor receives notice of the Member's Enrollment and prior to the first day of the month in which their Enrollment starts, the Contractor must provide the Member Handbook to each Member along with a cover letter providing a summary of the contents of the Member Handbook. At least annually, the Contractor shall notify all Members of their right to request and obtain the information specified in the Member Handbook and in this Contract.

The Contractor shall submit a copy of the Member Handbook to the Division for approval thirty (30) to sixty (60) calendar days prior to distribution and as part of the readiness review process. The Contractor must update the Member Handbook annually, addressing changes in policies through submission of a cover letter identifying sections that have changed and/or an electronic redlined handbook showing before and after language. Upon receipt of the initial Handbook and any changes thereafter, the Division will notify the Contractor of the time frame for its review. Any changes to content

subsequent to printing shall be corrected through an addendum or subsequent printing mutually agreed upon between the Contractor and the Division.

The Contractor shall give each of its Members thirty (30) calendar days' written notice of any material change to the MississippiCAN Program before its intended effective date.

When there are changes to covered services, benefits, or the process that the Member should use to access benefits, (i.e., different than as explained in the Member Handbook), the Contractor shall ensure that affected Members are notified of such changes at least fourteen (14) calendar days prior to their implementation.

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

1. Table of Contents;

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

3. Terms and conditions under which Member eligibility and coverage for Medicaid and the MississippiCAN Program may be terminated;

4. Procedures to be followed if Member wishes to change Contractors;

5. PCP roles and responsibilities in serving as a Medical Home in directing care;

6. Information about choosing and changing PCPs;

7. Making appointments and accessing care;

    a. Appointment-making procedures and appointment access standards;

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

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

    d. The extent to which, and how, Members may obtain benefits, including information about receiving care from Non-Contracted Providers; and

    e. Information about family planning services, including explanation that there are no restrictions on the choice of Provider from whom the Member may receive family planning services and supplies;

8. Member Services;

    a. Instructions on how to contact the Member Services Call Center and a

description of the functions of Member Services;

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

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

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

e. A description of all available covered services, including behavioral health, Non-Emergency Transportation, dental, maternity, pharmacy, and preventive services, services available to children in foster care, if applicable, and an explanation of any service limitations, referral and Prior Authorization requirements. This description should include that the Member may receive a minimum of a three (3)-day emergency supply for prior authorized drugs until authorization is completed;

f. Information about the features of Care Management, the responsibilities of the Contractor for coordination of Member care, and the Member's role in the Care Management process;

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

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

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

j. An explanation of any service limitations or exclusions from coverage; including limitations that may apply to services obtained from Non-Contracted Providers;

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

l. Instructions on how Members may access services that are covered under Mississippi Medicaid but not under the MississippiCAN Program;

m. Circumstances under which an eligible Member may disenroll or be involuntarily disenrolled from the Contractor and/or MississippiCAN Program;

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

10. Member Complaints, Grievances, and Appeals;

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

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

ii. Information on filing Complaints, Grievances, and State Fair Hearing procedures as specified in 42 C.F.R. § 438.10(g)(1);

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

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

v. The toll-free numbers that the Member can use to file a Complaint, Grievance, or an Appeal by telephone;

vi. A description of the continuation of benefits process required by 42 C.F.R. § 438.420 and information describing how the Member may request continuation of benefits, as well as information on how the Member may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Member; and

vii. Telephone numbers to register Complaints regarding Providers and the Contractor;

11. Emergency Medical Care;

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

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

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

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

e. Information indicating that emergency services are available without Prior Authorization and out-of-network emergency services are available without any financial penalty to the Member;

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

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

12. Member Identification Cards;

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

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

13. Interpretation and Translation Services;

a. Information on how to access verbal interpretation services, free of charge, for any non-English language spoken [42 C.F.R. § 438.10(c)(5)(i)];

b. A multilingual notice that describes translation services that are available and provides instructions explaining how Members can access those translation services [42 C.F.R. § 438.10(c)(5)(i)]; and

c. Information on how to access the handbook in an alternative format for special needs individuals including, for example, individuals with visual impairments [42 C.F.R. § 438.10(d)(2)];

14. Member Rights;

a. A description of Member rights and protections as specified in 42 C.F.R. § 438.100 and Section 6.I, Member Rights and Responsibilities, of this Contract as provided during open Enrollment;

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

c. Information about the Contractor's privacy policies;

15. Member Responsibilities;

a. A description of procedures to follow if:

i. The Member's family size changes;

ii. The Member moves out of state or has other address changes; and

iii. The Member obtains or has health coverage under another policy or there are changes to that coverage;

b. Actions the Member can make towards improving his or her own health, Member responsibilities and any other information deemed essential by the Contractor;

c. Information about the process that Members and Providers must follow when requesting inpatient Prior Authorization, including name and number of the Division's inpatient Prior Authorization vendor, and how to notify the Contractor of an inpatient admission;

d. Information about advance directives such as living wills or durable power of attorney, in accordance with 42 C.F.R. § 489.100 and 42 C.F.R. § 438.6 (i)(2-4); and

e. Information regarding the Member's repayment of capitation premium payments if Enrollment is discontinued due to failure to report truthful or accurate information when applying for Medicaid;

16. Contractor Responsibilities;

a. Additional information that is available upon request, including information about the structure and operation of the Contractor;

b. Additional information about physician incentive plans as set forth in 42 C.F.R. § 438.6(h); and

c. Notification to the Member that the Division should be notified if the Member has another health insurance policy and that the Contractor will coordinate the payment of claims between the two (2) insurance plans.

E. <u>Provider Directory</u>

The Contractor shall develop, regularly maintain and make available Provider Directories that include information for all types of Providers in the Contractor's network, including, but not limited to PCPs, hospitals, specialists, Providers of ancillary services, behavioral health facilities, and pharmacies. In accordance with 42 C.F.R. § 438.10(f)(6), the Provider Directory shall include, but is not limited to:

1. Names, locations, telephone numbers of, and non-English languages spoken by current contracted Providers in the Medicaid Member's area;

2. Identification of PCPs and PCP groups, specialists, and hospitals, facilities, FQHCs and RHCs by area of the State;

3. Identification of any restrictions on the Member's freedom of choice among network Providers;

4. Identification of Closed Panels (web-based version only); and

5. Identification of hours of operation including identification of Providers with non-traditional hours (Before 8 a.m. or after 5 p.m. CST or any weekend hours).

The Contractor shall make available hard copy Provider directories in State Medicaid Regional Offices, the CCOs' offices, WIC offices, upon Member request, and other areas as directed by the Division.

The Contractor must also utilize a web-based Provider Directory, which must be updated within five (5) business days upon changes to the Provider Network. The Contractor must establish a process to ensure the accuracy of electronically posted content, including a method to monitor and update changes in Provider information. The Contractor must perform monthly reviews of the web-based Provider Directory, subject to random monitoring by the Division to ensure complete and accurate entries.

The Contractor must submit its Provider Directory template to the Division for advance written approval prior to use and before distribution to its Members if there are significant format changes to the directory template.

F. Communication Standards

All written material provided to Members or potential Members, including all Marketing materials, plan booklets, descriptions and information, instructional materials, policies and procedures disclosures, notices and handbooks must meet requirements specified under 42 C.F.R. § 438.10 and meet the following requirements:

1. Documents are comprehensive yet written to meet a Flesch-Kincaid, or other Division-approved standard, total readability level that does not exceed the sixth (6th) grade level of reading comprehension. Materials must set forth the Flesch-Kincaid, or other approved standard, score and certify compliance with this standard. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.)

2. Documents are available in the prevalent non-English languages in the State of Mississippi, which is defined as five percent (5%) of the Contractor's enrolled Members who speak a common, non-English language, in compliance with the Division's Limited English Proficiency Policy.

3. Documents are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited in accordance with 42 C.F.R. § 438.10(d)(1)(ii).

All Enrollment, Disenrollment and educational documents and materials made available to Members by the Contractor must be submitted to the Division for review and approval

prior to release, unless specified elsewhere in this Contract. The Contractor must review all materials on an annual basis and provide a list of these materials to the Division annually indicating the review date. If the Contractor revises these materials, the Contractor will submit the updated materials to the Division for review and approval highlighting and using a redlined format for changes. The Contractor must meet the Division's required time frames for the submission of Deliverables in the event that requested Deliverables do not have a submission time frame specified, in accordance with Section 10.U, Deliverables, of this Contract. In such cases, the Division will specify the time frame for submission of Deliverables. The Division will notify the Contractor of the time frame it will require for review of Deliverables.

The Contractor shall also make verbal interpretation services available free of charge to each Member for all non-English languages and shall institute a mechanism for all Members who do not speak English to communicate effectively with their PCP and with Contractor staff and Subcontractors. Verbal interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education [42 C.F.R. § 438.10(c)(4)]. The Contractor must provide TTY/TDD services for the hearing impaired. Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the Member, family member of the Member, or a friend of the Member.

The Contractor shall notify Members that verbal interpretation services and interpretation services for the hearing impaired and vision-impaired are available and how to access those services.

The Contractor shall participate in the Division's efforts to promote the delivery of services in a culturally competent manner to all Members including those with limited English proficiency and diverse cultural and ethnic backgrounds.

G. Internet Presence/Website

The Contractor shall develop, host and maintain a website specific to the MississippiCAN Program. The Contractor shall provide general and up-to-date information about the Contractor's programs, Provider Network, customer services, and Member and Provider Grievance and Appeals systems on a non-secure section of the website. PHI shall be accessible through a secure section of the website.

The website must comply with the Marketing policies and procedures, requirements for written materials described in this Contract, and must be consistent with applicable State and Federal laws.

The Contractor shall submit website screenshots to the Division for review and approval prior to making the website available and as updated.

1. Member Portal

   The Contractor shall maintain a Member portal that allows Members to access a searchable Provider Directory. The Contractor shall also include a copy of the

Member Handbook, information about Member rights and responsibilities and the Complaints, Grievances, and Appeals process on the Member portal.

The website must have the capability for Members to submit questions and comments to the Contractor and for Members to receive responses.

2. Provider Portal

The Contractor shall dedicate a section of its website to Provider services and is encouraged to promote the use of the Provider portal among Providers. At a minimum, the Contractor's Provider portal must provide the following capabilities for Providers:

a. Ability to submit inquiries and receive responses;

b. Access to a copy of the Provider Manual;

c. Access to newsletters, updates, and Provider notices;

d. Access to a searchable Provider Directory;

e. Ability to link to the State's PDL;

f. Ability to submit Prior Authorization requests and view the status of such requests (e.g., approved, denied, pending);

g. Information about the process Providers must follow when requesting inpatient Prior Authorization, including name and number of the Division's inpatient Prior Authorization vendor, and how to notify the Contractor of an inpatient admission; and

h. Ability to submit, process, edit (only if original submission is in an electronic format), rebill, and adjudicate claims electronically.

To the extent a Provider has the capability, the Contractor shall submit electronic payments and remittance advices to Providers. Remittance advices must be provided within one (1) to five (5) business days of when payment is made.

H. Marketing

The Contractor may not directly market to individual Medicaid beneficiaries or potential Members and must adhere to the requirements specified by 42 C.F.R. § 438.104. The Division is responsible for creating a process to provide information about choice of Contractors and enrolling the beneficiaries into their chosen Contractor. All Marketing to potential Members will be handled by the Division and/or its Agent.

The Contractor shall develop Marketing materials such as written brochures and fact sheets. Marketing plans and materials shall not mislead, confuse, or defraud the

Members or the Division. Specifically, the Contractor cannot make any assertion or statement, whether written or verbal, that the Member must enroll in the Contractor's CCO in order to obtain benefits or to not lose benefits or that the Contractor is endorsed by CMS, the Federal or State government, or similar entity. The Contractor shall submit all Marketing materials to the Division thirty (30) business days prior to the planned distribution and the Division must approve these materials before they are released.

The Contractor shall maintain procedures to log and resolve Marketing Complaints, including procedures that address the resolution of Complaints against the Contractor, its employees, affiliated Providers, agents, or Subcontractors. These procedures shall contain a provision that a Contractor employee outside the Marketing department resolve or be involved in the resolution of Marketing/customer service Complaints. Marketing Complaints that cannot be satisfactorily resolved between the Contractor and the complainant must be forwarded to the Division for further investigation and resolution. Regardless of the resolution status of the Marketing Complaint, the Contractor must also submit the Marketing Complaint tracking log to the Division on a quarterly basis.

Marketing and promotional activities (including Provider promotional activities) must comply with all relevant Federal and State laws, including, when applicable, the anti-kickback statute, civil monetary penalty prohibiting inducements to Members. An organization may be subject to sanctions if it offers or gives something of value to a Member that the organization knows or should know is likely to influence the Member's selection of a particular Provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid. Additionally, organizations are prohibited from offering rebates or other cash inducements of any sort to Members.

1. Marketing Services

   The Contractor shall:

   a. Submit to the Division for prior written approval a work plan of planned Marketing activities annually;

   b. Submit a log of all completed Marketing activities quarterly;

   c. Submit all new and/or revised Marketing and informational materials or proposed changes to the Marketing work plan to the Division before their planned distribution or implementation (42 C.F.R. § 438.104). Upon receipt, the Division will specify the time frame for completing review. The Contractor may distribute Marketing materials to Medicaid beneficiaries where the Member is currently enrolled with the Contractor, assuming that the Division has approved the Marketing materials for distribution to Members;

   d. Coordinate and submit to the Division all schedules, plans, and informational materials for community education, networking and outreach programs. The Contractor shall submit the schedule to the Division at least two (2) weeks prior to any event and must be approved by the Division;

e. Assure that all Marketing and informational materials shall set forth the Flesch-Kincaid, or other approved standard, readability scores at or below sixth (6th) grade reading level and certify compliance therewith; and

f. Be subject to a fine or other sanctions if it conducts any Marketing activity that is not approved in writing by the Division (42 C.F.R. § 438.700).

2. Allowable Contractor Marketing Activities

The Contractor may engage in the following promotional activities with prior Division approval:

a. Notification to the public of the Contractor in general in an appropriate manner through appropriate media, throughout its Enrollment area;

b. Distribution through the Division or the Division's Agent of promotional materials pre-approved by the Division;

c. Pre-approved informational materials for television, radio, and newspaper dissemination;

d. Marketing and/or networking at community sites or other approved locations for name recognition, which must be prior approved by the Division;

e. Hosting or participating in health awareness events, community events, and health fairs, pre-approved by the Division, in which the Division also participates or provides observation of Contractor participation. Prior approved non-cash promotional items are permitted, but not for solicitation purposes. The Division will be responsible for supplying copies of the benefit charts, if distributed at such events; and

f. The Contractor is allowed to offer non-cash incentives to their Members for the purposes of rewarding for compliance in immunizations, prenatal visits, participating in Care Management, or other behaviors as pre-approved by the Division. The Contractor shall analyze Member data to identify gaps in care and areas to improve outcomes. The Contractor must provide to the Division for approval information about the interventions the Contractor will employ to improve upon those gaps, including Member incentives the Contractor will provide to Members, and the expected impact of the incentives, along with a plan to evaluate the impact of those incentives. The Contractor is encouraged to use items that promote good health behavior, e.g., toothbrushes or immunization schedules. This incentive shall not be extended to any individual not yet enrolled in the Contractor. The Contractor must submit all incentive award packages to the Division for approval prior to implementation.

3. Prohibited Marketing and Outreach Activities

The following are prohibited Marketing and outreach activities targeting prospective

Members under this Contract:

a. Engaging in any informational or Marketing activities which could mislead, confuse, or defraud Members or misrepresent the Division (42 C.F.R. § 438.104);

b. Directly or indirectly, conducting door-to-door, telephonic, or other "cold call" Marketing of Enrollment at residences and Provider sites (42 C.F.R. § 438.104);

c. Sending direct mailing (all Marketing mailings must be processed through the Division or its Agent to Members of the Contractor);

d. Making home visits for Marketing or Enrollment;

e. Offering financial incentive, reward, gift, or opportunity to eligible Members as an inducement to enroll with the Contractor other than to offer the health care benefits from the Contractor pursuant to their contract or as permitted above;

f. Continuous, periodic Marketing activities to the same prospective Member (e.g., monthly or quarterly) giveaways, as an inducement to enroll;

g. Using the Division eligibility database to identify and market itself to prospective Members or any other violation of confidentiality involving sharing or selling Member lists or lists of eligibles with any other person or organization for any purpose other than the performance of the Contractor's obligations under this Contract;

h. Engaging in Marketing activities which target prospective Members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services;

i. Contacting Members who disenroll from the Contractor by choice after the effective Disenrollment date except as required by this Contract or as part of a Division approved survey to determine reasons for Disenrollment;

j. Engaging in Marketing activities which seek to influence Enrollment or induce giving the Contractor the names of prospective Members in conjunction with the sale or offering of any private insurance (42 C.F.R. § 438.104);

k. No Enrollment related activities may be conducted at any Marketing, community, or other event;

l. No educational or Enrollment related activities may be conducted at Department of Human Services offices unless authorized in advance by the Division;

m. No assertion or statement (whether written or verbal) that the Contractor is endorsed by the Centers for Medicare and Medicaid Services (CMS); Federal or State government; or similar entity (42 C.F.R. § 438.104); and

n. No assertion or statement that the Member must enroll with the Contractor in order to obtain or lose benefits (42 C.F.R. § 438.104).

I. Member Rights and Responsibilities

In accordance with 42 C.F.R. § 438.100, the Contractor shall have written policies and procedures regarding Member rights and shall ensure compliance of its staff and affiliated Providers with any applicable Federal and State laws that pertain to Member rights. Policies and procedures shall include compliance with: Title VI of the Civil Rights Act of 1964, as implemented at 45 C.F.R. Part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 C.F.R. Part 91; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality.

1. Member Rights

At a minimum, such Member rights include the right to:

a. Receive information in a manner and format that may be easily understood in accordance with 42 C.F.R. § 438.10;

b. Be treated with respect and with due consideration for his or her dignity and privacy;

c. Receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand;

d. Participate in decisions regarding his or her health care, including the right to refuse treatment;

e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;

f. Request and receive a copy of his or her Medical Records and request that they be amended or corrected, as specified in 45 C.F.R. § 164.524 and 164.526;

g. Free exercise of rights and the exercise of those rights do not adversely affect the way the Contractor and its Providers treat the Member; and

h. Be furnished health care services in accordance with 42 C.F.R. § 438.206 through 438.210.

The written policies and procedures shall also address the responsibility of Members to pay for unauthorized health care services obtained from non-participating Providers and their right to know the procedures for obtaining authorization for such services. The Contractor shall also have policies addressing the responsibility of each Member to cooperate with those providing health care services by supplying

information essential to the rendition of optimal care, following instructions and guidelines for care that they have agreed upon with those providing health care services, and showing courtesy and respect to Providers and staff. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members. A copy of the Contractor's policies and procedures regarding Member rights and responsibilities shall be provided to all contracted Providers and any Non-Contracted Providers to whom Members may be referred.

2. Member Protections

The Contractor agrees to protect Members from certain payment liabilities and not hold Members liable for:

a. Any and all debts of the Contractor if it should become insolvent;

b. Payment for services provided by the Contractor if the Contractor has not received payment from the State for the services, or if the Provider, under contract or other arrangement with the Contractor, fails to receive payment from the State or Contractor;

c. The payments to Providers that furnish covered services under a contract or other arrangement with the Contractor that are in excess of the amount that normally would be paid by the Member if the services had been received directly from the Contractor; and

d. The Contractor agrees to honor and be bound by Section 1128B(d)(1) of the Balanced Budget Act of 1997 which protects Members against balance billing by Subcontractors.

J. Member Complaint, Grievance, and State Fair Hearing Process

The Contractor shall draft and disseminate to Members, Providers, and Subcontractors, a system and procedure, which has the prior written approval of the Division for the receipt and adjudication of Complaints, Grievances, and Appeals by Members. The Complaint, Grievance and Appeal policies and procedures shall be in accordance with 42 C.F.R. Part 438, Subpart F and the State's Quality Strategy, with the modifications that are incorporated in the contract and Exhibit D, Member Complaint, Grievance, Appeal, and State Fair Hearing Process, of this Contract. The Contractor shall not modify the Grievance and Appeal procedure without the prior approval of the Division, and shall provide the Division with a copy of the modification.

The Contractor shall review the Complaint, Grievance and Appeal procedure at reasonable intervals, but no less than annually, for amending as needed, with the prior written approval of the Division, in order to improve said system and procedure.

The Division shall have the right to intercede on a Member's behalf at any time during the Contractor's Complaint, Grievance, and/or Appeal process whenever there is an

indication from the Member, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately. Additionally, the Member may be accompanied by a representative of the Member's choice to any proceedings.

The Contractor shall provide Members as a part of the Member handbook, information on how they or their representative(s) can file a Grievance or an Appeal, and the resolution process. The Member information shall also advise Members of their right to file a request for a State Fair Hearing with the Division of Medicaid, upon notification of a Contractor Action, subsequent to an Appeal of the Contractor Action. The Member must exhaust all CCO level Grievance and Appeal procedures prior to requesting a State Fair Hearing with the Division.

The Contractor shall use the definitions for Complaints, Grievances, and Appeals as set forth in this section and adhere to time frames required by this Contract and Federal regulations. Table 3 below and Exhibit D, Member Complaint, Grievance, Appeal, and State Fair Hearing Process, of this Contract outline additional specific requirements pertaining to Complaints, Grievances, and Appeals.

Table 3. Summary of Member Complaints, Grievances, and Appeals Requirements

Party	Action	Time Frame	Extensions Available
Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt. Any Complaint not resolved within one (1) business day shall be treated as a Grievance. A Complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.			
Member	Submit a Complaint	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Respond to a Complaint	Within one (1) business day	
Grievance: An expression of dissatisfaction received orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Action as defined in this contract. A Grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or an employee, or failure to respect the Members rights.			
Member or Provider	File a Grievance	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	

Party	Action	Time Frame	Extensions Available
Contractor	Confirm receipt of Grievance and expected date of resolution	Within ten (10) calendar days of receipt of the Grievance	
Contractor	Resolve a Grievance	Within thirty (30) calendar days of the date the Contractor receives the Grievance or as expeditiously as the Member's health condition requires	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)
Appeal: A request for review by the Contractor of a Contractor Action.			
Member or Provider	File an Appeal	Within thirty (30) calendar days of receiving the Contractor's notice of Action	
Contractor	Confirm receipt of the Appeal and expected date of resolution	Within ten (10) calendar days of receipt of the Appeal	
Contractor	Resolve an Appeal	Within forty-five (45) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires Within three (3) business days after the Contractor receives the request for an Expedited Resolution of an Appeal	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)
State Fair Hearing: A hearing conducted by the Division of Medicaid or its Subcontractor in accordance with 42 CFR § 431 Subpart E. Any adverse Action or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's authorized representative to the Division for a State Fair Hearing conducted in accordance with 42 CFR Part 431 Subpart E.			
Member or Provider	File a request for a State Fair Hearing	Within thirty (30) calendar days of the final decision by the Contractor	

Party	Action	Time Frame	Extensions Available
Division	Take final administrative Action	Within ninety (90) calendar days from the date the Member filed for direct access to a State Fair Hearing Or as expeditiously as the Member's health condition requires but no later than three (3) business days after the Division receives from the Contractor the case file and information for circumstances that meet criteria for Expedited Resolution as set forth in 42 C.F.R. § 438.410(a) but was not resolved within the time frame for Expedited Resolution or it was resolved within the time frame but reached a decision wholly or partially adverse to the Member	

Nothing in this Contract shall be construed as removing any legal rights of Members under State or Federal law, including the right to file judicial actions to enforce rights.

SECTION 7 – PROVIDER NETWORK

The Contractor must submit reports related to Provider Networks in accordance with Section 10, Reporting Requirements, and Exhibit H, Reporting Requirements, of this Contract.

A. **General Requirements**

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

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

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

B. **Provider Network Requirements**

1. Geographic Access Standards

   In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Contractor shall meet the geographic access standards for all Members set forth in Table 4.

Table 4. Geographic Access Standards

Provider Type	Urban	Rural
PCPs	Two (2) within fifteen (15) miles	Two (2) within thirty (30) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Emergency Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within thirty (30) minutes or thirty (30) miles
Urgent Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	Not Applicable

Provider Type	Urban	Rural
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within thirty (30) minutes or thirty (30) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within sixty (60) minutes or sixty (60) miles
Dialysis Providers	One (1) within sixty (60) minutes or sixty (60) miles	One within ninety (90) minutes or ninety (90) miles

The Division shall specify the urban and rural designation of counties within Mississippi. All travel times are maximums for the amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the Provider. The Division recognizes that Non-Emergency Transportation Providers may not always follow direct routes due to multiple passengers.

If the Contractor is unable to identify a sufficient number of Providers located within an area to meet the geographic access standards, or is unable to identify a sufficient number of Providers within a Provider type or specialty, the Contractor will submit documentation to the Division verifying the lack of Providers. The Division may approve exceptions to the geographic access standards in such cases. The Division may impose penalties under Section 15, Default and Termination, of this Contract if the Contractor fails to meet Provider Network access standards.

The Contractor must pay for services covered under the contract on an out-of-network basis for the Member if the Contractor's Provider Network is unable to provide such services within the geographic access standards. The Contractor shall ensure that the cost to the Member is no greater than it would be if the services were furnished within the network. Services must be provided and paid for in an adequate and timely manner, as defined by the Division, and for as long as the Contractor is unable to provide them.

The Contractor shall submit a Network Geographic Access Assessment (GeoAccess) Report on a quarterly basis to the Division demonstrating compliance with these requirements.

2. Accessibility

The Contractor shall have in its network the capacity to ensure that the appointment scheduling does not exceed those set forth in Table 5.

Table 5. Appointment Scheduling Time Frames

Type	Appointment Scheduling Time Frames
PCPs (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (Urgent Care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed twenty-one (21) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

Each network physician shall maintain hospital admitting privileges with a network hospital as required for the performance of his or her practice or have a written agreement with a network physician who has hospital admitting privileges.

All network Providers must be accessible to Members and must maintain a reasonable schedule of operating hours. At least annually, the Contractor must conduct a review of the accessibility and availability of PCPs and must follow-up with those Providers who do not meet the accessibility and availability standards set forth by the Division in this contract. The Contractor will submit the findings from this review in writing to the Division.

The Division shall have the right to periodically review the adequacy of service locations and hours of operation, and will require corrective action to improve Member access to services.

3. Direct Access

   The Contractor must provide female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist.

4. Second Opinions

   Upon request, the Contractor must provide for a second opinion from a qualified health care professional within the network, or arrange for the Member to obtain one outside the network from a Non-Contracted Provider, at no cost to the Member.

5. Patient-Centered Medical Homes

   The Contractor shall encourage the development of NCQA-recognized Patient-Centered Medical Homes and coordinate with any Division-level initiatives related to the development and NCQA recognition of Patient-Centered Medical Homes, as defined by the Division. Based on the collaboration with the Division, the Division will define specific reporting requirements which may change as the initiative is implemented. The Division will notify the Contractor of the reporting requirements in writing at least sixty (60) days before the report containing the required information is due.

6. Additional Requirements

   The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency.

   The Contractor shall also not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of the Member who is his or her patient for the following:

   a. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

   b. Any information the Member needs in order to decide among all relevant treatment options;

   c. The risks, benefits, and consequences of treatment or non-treatment;

   d. The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future

treatment decisions; or

e. The Member may be responsible for non-covered item(s) and/or service(s) only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Member that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Member will be financially responsible for the item(s) and/or service(s).

C. **PCP Responsibilities**

The Contractor shall require PCPs to meet the following requirements:

1. PCPs who serve Members under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Member's PCP Medical Record.

2. PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by the Division, to the Contractor within ninety (90) calendar days from the date of service.

3. PCPs are responsible for contacting new Members identified in the quarterly encounter lists sent by the Contractor that indicate who has not had an encounter during the first six (6) months of Enrollment. The Contractor must require the PCP to:

   a. Contact Members identified in the quarterly Encounter lists as not complying with EPSDT periodicity and immunization schedules for children;

   b. Identify to the Contractor any such Members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such notification to the site by the Contractor; and

   c. Document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards.

4. Specialists as PCPs

Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by the Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a Provider participating in the Contractor's network.

The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with the Contractor's standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

The Contractor shall have in place procedures for ensuring access to needed services for these Members or shall grant these PCP requests, as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures.

D. **Provider Terminations**

If a Member's PCP, specialist, or other Provider is no longer available to the Member through the Contractor's network, the Contractor shall have a plan to ensure continuity and coordination of care and to assist the Member in selecting a network Provider.

1. Termination by the Contractor

The Contractor must notify the Division in writing of its intent to terminate a contracted Provider and services provided by a contracted Provider (which includes a specialty unit within a facility and/or a large Provider group) sixty (60) calendar days prior to the effective date of the termination. The Contractor must submit a Provider termination work plan and supporting documentation within ten (10) business days of the Contractor's notification to the Division of the termination and must provide weekly updates to this information. This work plan shall document work steps and due dates and shall include, but is not limited to the submission of:

a. Provider Impact and Analysis;

b. Updated Provider Network and/or Provider Affiliation File;

c. Provider Notification of the Termination;

d. Member Impact and Analysis;

e. Member Notification of the Termination;

f. Member Transition and Continuity of Care;

g. Systems Changes;

h. Provider Directory Updates for the Division's Agent (include date when all updates will appear on Provider files);

i. Contractor Online Directory Updates;

j. Submission of Required Documents to the Division (Member notices for prior approval);

k. Submission of Final Member Notices to the Division;

l. Communication with the public related to the termination; and

m. Termination Retraction Plan, if necessary.

The Division may also request additional background information regarding the Provider termination, including but not limited to a summary of the issues, reasons for the termination, and information on negotiations or outreach between the Contractor and Provider.

The Contractor must deny or revoke a Provider Agreement for cause for any reasons set forth in 42 C.F.R. §§ 455.420, 1001.1001 and Miss. Code Ann. § 43-13-121(7).

Unless the Provider is being terminated for cause, the Contractor must allow a Member to continue an ongoing course of treatment from the Provider for up to sixty (60) calendar days from the date the Member is notified by the Contractor of the termination or pending termination of the Provider, or for up to sixty (60) calendar days from the date of Provider termination, whichever is greater. A Member is considered to be receiving an ongoing course of treatment from a Provider under the following circumstances:

a. During the previous twelve (12) months the Member was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized;

b. An adult Member with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the Provider, unless the appointment is for a well adult check-up;

c. Any child (under age 21) with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing course of treatment from the Provider; or

d. A Member who is pregnant may continue to receive care from the Provider that is being terminated through the completion of the Member's postpartum care.

The transitional period may be extended by the Contractor if the extension is determined to be clinically appropriate. The Contractor shall consult with the Member and the health care Provider in making the determination. The Contractor must review each request to continue an ongoing course of treatment and notify the Member of the decision as expeditiously as the Member's health condition requires, but no later than two (2) business days. If the Contractor determines that what the Member is requesting is not an ongoing course of treatment, the Contractor must issue the Member a denial notice.

The Contractor must also inform the Provider that to be eligible for payment for services provided to a Member after the Provider is terminated from the network, the Provider must agree to meet the same terms and conditions as participating Providers.

2. Termination by the Provider

If the Contractor is informed by a Provider that the Provider intends to no longer participate in the Contractor's Network, the Contractor must notify the Division in writing sixty (60) calendar days prior to the date the Provider will no longer participate in the Contractor's network. If the Contractor receives less than sixty (60) calendar days' notice that a Provider will no longer participate in the Contractor's Network, the Contractor must notify the Division within two (2) business days after receiving notice from the Provider.

The Contractor must submit a Provider termination work plan that includes the elements listed in Section 7.D.1, Termination by the Contractor, above within ten (10) business days of the Contractor notifying the Division of the termination and must provide weekly status updates to the work plan.

3. Member Notification

The Contractor shall send a written notice within fifteen (15) calendar days of notice or issuance of termination of a Provider to Members who receive primary care from the Provider, who are treated on a regular basis from the Provider, or who are affected by the loss of the Provider for other reasons. The written notice shall include information about selecting a new Provider, and a date after which Members who are undergoing an active course of treatment cannot use the terminated Provider. The Contractor shall receive Division prior approval for Member notices.

E. **Provider Credentialing and Qualifications**

The Contractor must follow a documented process for credentialing and recredentialing of Providers who have signed contracts or participation agreements with the Contractor, in accordance with 42 C.F.R. § 438.214 and Mississippi Department of Insurance Regulation 98-1. The Contractor shall maintain a Credentialing Committee and the Contractor's Medical Director shall have overall responsibility for the committee's activities.

The Contractor shall use credentialing and recredentialing standards set forth by the National Committee for Quality Assurance (NCQA) and EQRO recommendations. The Contractor must follow the most current version of the credentialing organization's credentialing requirements from year to year.

The Contractor shall verify and certify to the Division that all contracted Providers and any Non-Contracted Providers to whom Members may be referred are properly licensed in accordance with all applicable State law and regulations, are eligible to participate in the Medicaid program, and have in effect appropriate policies of malpractice insurance as may be required by the Contractor and the Division. All Contractor contracted Providers must also be enrolled in the Mississippi Medicaid program using the same National Provider Identifier (NPI) numbers. Contracted nurse practitioners acting at PCPs shall be held to the same requirements and standards as physicians acting at PCPs.

In contracting with Providers, the Contractor will be responsible for obtaining all disclosure information from all contracted Providers and Non-Contracted Providers and abide by all applicable Federal regulations, including 42 C.F.R. § 455.104 and § 455.106. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the State, cover page of malpractice insurance, and such additional information as may be specified by the Division.

In contracting with laboratory Providers and or any Provider who bills for laboratory services, the Contractor must ensure that all laboratory testing sites providing services under the contract have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. Provider attestation of CLIA certificate is not acceptable. The Contractor shall maintain copies of the CLIA certificate or waiver of the certificate of registration in the Provider's credentialing and recredentialing files.

The process for verification of Provider credentials and insurance and periodic review of Provider performance shall be embodied in written policies and procedures, approved in writing by the Division as part of the readiness review prior to implementation. Credentialing policies and procedures must meet Federal, State, and Division requirements and shall include:

1. The verification of the existence and maintenance of credentials, licenses, malpractice claims history, certificates, and insurance coverage of each Provider from a primary source, site assessment;

2. A methodology and process for recredentialing Providers;

3. A description of the initial quality assessment of private practitioner offices and other patient care settings conducted in-person during the Provider office visit;

4. Procedures for disciplinary action, such as reducing, suspending, or terminating Provider privileges;

5. Procedures for practitioners to correct erroneous information;

6. Process for making available to practitioners the Contractor's confidentiality requirements to ensure that all information obtained in the credentialing process is confidential except as otherwise provided by law;

7. Procedures for verifying that contracted nurse practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility; and

8. Procedures for verifying the inclusion of Providers including but not limited to the following databases: HHS-OIG's List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) Excluded Parties List Service (EPLS), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, National Practitioner Data Bank (NPDB), Health Integrity and Protection Databank (HIPDB), and any State listings of excluded Providers. Copies or prints of all queries shall be included in Provider credentialing files.

The Contractor shall allow practitioners to review the information submitted in support of the practitioner's credentialing application.

The Contractor shall notify a practitioner of any information obtained during the credentialing process that varies substantially from the information provided to the Contractor by the practitioner.

The Contractor shall credential all completed application packets within ninety (90) calendar days of receipt. In cases of network inadequacy, the Contractor shall credential all completed application packets within forty-five (45) calendar days of receipt. The Contractor shall notify the Division of any Provider applications requiring longer than ninety (90) calendar days via quarterly report.

The Contractor shall notify the Division within ten (10) calendar days of the Contractor's denial of a Provider credentialing application either for program integrity-related reasons or due to limitations placed on the Provider's ability to participate for program integrity-related reasons.

The Contractor must submit reports in accordance with Section 10.E, Provider Services Reports, of this Contract.

F. **Provider Agreements**

The Contractor must have written agreements with a sufficient number of Providers to ensure Member access to all Medically Necessary Services covered by the MississippiCAN Program.

Contracts with all behavioral health Providers must have provisions that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Contractor is aware of the Member's inpatient hospitalization status. The Division's Utilization Management Contractor will provide daily reports to the Contractor to

identify Members admitted to an inpatient facility.

In all Provider agreements, the Contractor must comply with the requirements specified in 42 C.F.R. § 438.214. The Contractor's Provider agreements must include at least the following provisions:

1. A requirement that the Contractor must not exclude or terminate a Provider from participation in the Contractor's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

2. A requirement to ensure that Members are entitled to the full range of their health care Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of this Contract. Any contractual provisions, including gag clauses or rules, that restricts a health care Provider's ability to advise patients about medically necessary treatment options violate Federal law and regulations.

3. A requirement that the Contractor cannot prohibit or restrict a Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member including; information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

4. A requirement that the Contractor cannot prohibit or restrict a Provider acting within the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.

5. A requirement that the Contractor cannot terminate a contract or employment with a Provider for filing a Complaint, Grievance, or Appeal on a Member's behalf.

6. A requirement securing cooperation with the QM and UM Program standards outlined in Section 9, Quality Management, of this Contract.

7. A requirement that PCPs comply with requirements of Section 7.C, PCP Responsibilities, of this Contract.

8. A requirement that the Contractor include in all capitated Provider agreements a clause which requires that should the Provider terminate its agreement with the Contractor, for any reason, the Provider will provide services to the Members assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.

9. A requirement that the Provider must comply with all applicable laws and regulations pertaining to the confidentiality of Member Medical Records, including obtaining any required written Member consents to disclose confidential Medical Records.

10. A requirement that the Provider must make referrals for social, vocational, education or human services when a need for such service is identified.

11. In the event the Contractor becomes insolvent or unable to pay the participating Provider, a requirement that the Provider shall not seek compensation for services rendered from the State, its officers, Agents, or employees, or the Members or their eligible dependents.

12. A requirement that, effective July 1, 2014, the Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial.

The Contractor may not enter into a Provider agreement that prohibits the Provider from contracting with another CCO or that prohibits or penalizes the Contractor for contracting with other Providers. The Contractor may not require Providers who agree to participate in the MississippiCAN Program to contract with the Contractor's other lines of business.

G. **Mainstreaming**

The Contractor must ensure that network Providers do not intentionally segregate their Members in any way from other persons receiving services.

The Contractor must investigate Complaints regarding Providers and take affirmative action so that Members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

1. Denying or not providing a Member any Medicaid covered service or availability of a facility within the Contractor's network. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

2. Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members, public or private patients, in any manner related to the receipt of any Medicaid covered service, except where medically necessary.

3. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, language, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the Members to be served.

If the Contractor knowingly executes an agreement with a Provider with the intent of allowing or permitting the Provider to implement barriers to care (e.g., the terms of the Provider agreement are more restrictive than this Contract), the Contractor shall be in breach of this Contract.

H. **Provider Services**

The Contractor must submit reports in accordance with Section 10.E, Provider Services Reports, of this Contract.

1. Provider Services Call Center

The Contractor must operate Provider services call center functions at a minimum during regular business hours (8:00 a.m. to 5:00 p.m. CST, Monday through Friday). Provider services functions include, but are not limited to, the following:

a. Assisting Providers with questions concerning Member eligibility status;

b. Assisting Providers with Contractor Prior Authorization and referral procedures;

c. Assisting Providers with claims payment procedures and handling Provider disputes and issues;

d. Facilitating transfer of Member Medical Records among medical Providers, as necessary;

e. Providing to PCPs a monthly list of Members who are under their care, including identification of new and deleted Members; An explanation guide detailing use of the list must also be provided to PCPs;

f. Referring Providers to the Fraud and Abuse Hotline;

g. Developing a process to respond to Provider inquiries regarding current Enrollment; and

h. Coordinating the administration of out-of-network services.

The Contractor must develop appropriate, interactive scripts for call center staff to use when making outbound calls to Providers and to respond to Providers calls. The Contractor must develop special scripts for emergency and unusual situations, as requested by the Division. All scripts must be clear and easily understood. All scripts shall promote the use of the Contractor's web-based Provider portal. The Contractor must review the scripts annually to determine any necessary revisions. The Division reserves the right to request and review call center scripts at any time.

The Contractor shall randomly select and record calls received at the call center and monitor no less than three percent (3%) of calls for compliance with customer care guidelines. The Contractor will report the findings of these audits to the Division via

a quarterly Deliverable report. The Contractor will make recordings available to the Division upon request within five (5) business days. The Contractor shall maintain the recordings for at least twelve (12) months.

The Contractor shall maintain sufficient equipment and call center staff for Provider services call center to ensure that the average abandonment rate for any month is not greater than five percent (5%). The Contractor will be subject to sanctions if the abandonment rate exceeds this target, in accordance with Section 15, Default and Termination, of this Contract.

2. Provider Manual

The Contractor shall develop and maintain a Provider manual for network Providers. Copies of the Provider manual must be distributed in a manner that makes them easily accessible to all participating Providers, including provision of an electronic version through the web portal. The Provider manual must be approved by the Division prior to use.

The Provider manual must be updated annually and approved by the Division prior to use. The Division may grant an exception to this annual requirement upon written request from the Contractor provided there are no major changes to the manual.

The Provider manual must include, at a minimum, the following information:

a. Description of the Care Management system and protocols;

b. Description of the role of a PCP;

c. Information about how Members may access specialists, including standing referrals and specialists as PCPs;

d. Contact follow-up responsibilities for missed appointments;

e. Information regarding written translation and verbal interpretation services for Members with Limited English Proficiency and alternate methods of communication for those requesting communication in alternate formats;

f. Information about filing Provider disputes;

g. Complaint, Grievance, Appeal, and State Fair Hearing information;

h. Billing instructions, including claims submission time frame requirements;

i. Provider performance expectations, including disclosure of quality management and utilization management criteria and processes;

j. Information about EPSDT screening requirements and EPSDT services;

k. Provider responsibility to follow up with Members who are not in compliance

with the EPSDT screening requirements and EPSDT services;

l. A definition of "medically necessary" consistent with the language in this Contract;

m. Prior authorization requirements, including the requirement that a Member may receive a minimum of a three (3) day emergency supply for prior authorized drugs until authorization is completed;

n. Information about Member confidentiality requirements;

o. Information about the process for communicating with the Contractor on limitations on Panel size;

p. Information about the process for contacting the Contractor regarding assignment of a Member to an alternate PCP;

q. Explanation of the Division's requirements that the Contractor may not require the Provider to agree to non-exclusivity requirements nor to participate in the Contractor's other lines of business to participate in MississippiCAN; and

r. Description of the web portal information available through the portal and the process for accessing it.

3. Provider Education and Training

The Contractor shall provide training to all Providers and their staff regarding the requirements of the contract and special needs of Members, including EPSDT services. The Contractor shall conduct initial training within thirty (30) calendar days of placing a newly contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by the Contractor or the Division or as requested by the Provider to ensure compliance with program standards and the Contract.

The Contractor shall develop and submit a Provider Training Manual and prospective Training Plan to the Division for review and approval initially and as updated prior to use. The Contractor will submit quarterly reports on the trainings conducted, topics covered, the number and positions of staff completing the trainings, and trainings planned in the subsequent quarter.

The Contractor shall also conduct, in collaboration with the Division, a minimum of ten (10) MississippiCAN Workshops annually targeting Providers. The Division will notify the Contractor of the dates, times, and locations for workshops.

I. **Provider Complaint, Grievance, and State Fair Hearing Process**

The Contractor shall draft and disseminate to Providers and Subcontractors, a system and procedure, which has the prior written approval of the Division for the receipt and

adjudication of Complaints, Grievances, and Appeals by Providers. The Grievance and Appeal policies and procedures shall be in accordance with the State's Quality Strategy, with the modifications that are incorporated in the contract. The Contractor shall not modify the Grievance and Appeal procedure without the prior approval of the Division, and shall provide the Division with a copy of the modification.

The Contractor shall review the Grievance and Appeal procedure at reasonable intervals, but no less than annually, for amending as needed, with the prior written approval of the Division, in order to improve said system and procedure.

The Division shall have the right to intercede on a Provider's behalf at any time during the Contractor's Complaint, Grievance, and/or Appeal process whenever there is an indication from the Provider, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately.

The Contractor shall provide Providers as a part of the Provider Manual, information on how they or their representative(s) can file a Grievance or an Appeal, and the resolution process. The information shall also advise Providers of their right to file a request for a State Fair Hearing with the Division of Medicaid, upon notification of a Contractor Action, subsequent to an Appeal of the Contractor Action. The Provider must exhaust all CCO level Grievance and Appeal procedures prior to requesting a State Fair Hearing with the Division.

The Contractor shall use the definitions for Complaints, Grievances, and Appeals as set forth in this section and adhere to time frames required by this Contract and Federal regulations. Table 6 below outlines additional specific requirements pertaining to Complaints, Grievances, and Appeals.

Table 6. Summary of Provider Complaints, Grievances, and Appeals Requirements

Party	Action	Time Frame	Extensions Available
Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt. Any Complaint not resolved within one (1) business day shall be treated as a Grievance. A Complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.			
Provider	Submit a Complaint	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Respond to a Complaint	Within one (1) business day	

Party	Action	Time Frame	Extensions Available
Grievance: An expression of dissatisfaction received orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Action as defined in this contract. A Grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or an employee.			
Provider	File a Grievance	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Confirm receipt of the Grievance and expected date of resolution	Within ten (10) calendar days of receipt of the Grievance	
Contractor	Resolve a Grievance	Within thirty (30) calendar days of the date the Contractor receives the Grievance	Contractor may extend time frames up to fourteen (14) calendar days
Appeal: A request for review by the Contractor of a Contractor Action.			
Provider	File an Appeal	Within thirty (30) calendar days of receiving the Contractor's notice of Action	
Contractor	Confirm receipt of the Appeal and expected date of resolution	Within ten (10) calendar days of receipt of the Appeal	
Contractor	Resolve an Appeal	Within forty-five (45) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires Within three (3) business days after the Contractor receives the request for an Expedited Resolution of an Appeal	Contractor may extend time frames by up to fourteen (14) calendar days

Party	Action	Time Frame	Extensions Available
State Fair Hearing: A hearing conducted by the Division of Medicaid or its Subcontractor. Any adverse Action or Appeal that is not resolved wholly in favor of the Provider by the Contractor may be appealed by the Provider or the Provider's authorized representative to the Division for a State Fair Hearing.			
Provider	File a request for a State Fair Hearing	Within thirty (30) calendar days of the final decision by the Contractor	
Division	Take final administrative Action	Within ninety (90) calendar days from the date the Provider filed for direct access to a State Fair Hearing	

Nothing in this Contract shall be construed as removing any legal rights of Providers under State or Federal law, including the right to file judicial actions to enforce rights.

J. **Reimbursement**

The Contractor shall reimburse Non-Contracted Providers for the following covered services specialty care for which the Contractor has referred the Member to a Non-Contracted Provider and out-of-area services provided to a Member in accordance with the Contractor's approved plan for out-of-network services.

The Contractor shall reimburse all contracted Providers at a rate no less than the prevailing Medicaid Fee-for-Service delivery system fee schedule with the exception of capitation and other incentive arrangements under Section 7.K, Physician Incentive Plans, of this Contract. The Contractor shall follow the Mississippi State Plan related to enhanced payment for primary care services.

The Contractor shall be responsible for full payment for services received by Members from Non-Contracted Providers because the Contractor's services were not available as required pursuant to the terms of this Contract.

The Contractor shall generate Explanations of Benefits, in a format approved by the Division and submit the policy and procedures for sampling for Explanation of Benefits for Division approval. The Contractor must send the Explanation of Benefits to Members within thirty (30) calendar days of adjudication.

1. Claims Payment

The Contractor will be responsible for processing claims. In accordance with 42 C.F.R. § 447.46, the Contractor must pay at least ninety percent (90%) of all clean claims (claims that pass all edits required for payments by the Contractor) for covered services within thirty (30) calendar days of receipt and pay at least ninety-

nine percent (99%) of all clean claims within ninety (90) calendar days of receipt, except to the extent an alternative payment schedule has been agreed to in the contract. For other claims, the Contractor shall notify the Provider of the status (e.g., pend, deny, or other reason) of the claim and if applicable, the reason the claim cannot be paid within thirty (30) calendar days of the adjudication of the claim. The Contractor must pay all other claims, except those from Providers under investigation for Fraud and Abuse, within twelve (12) months of the date of receipt.

Claims pending or suspended for additional information must be closed (paid or denied) by the sixtieth (60th) calendar day following the date the claim is suspended if all requested information is not received prior to the expiration of the sixty (60) calendar day period. The Contractor shall send Providers written notice (notification via e-mail or by mail satisfies this requirement) for each claim that is denied, including the reason(s) for the denial.

Claims for Emergency Medical Services and Family Planning Services shall be paid at the applicable Medicaid Fee-for-Service rate in the absence of an agreement otherwise between the Contractor and the Non-Contracted Provider.

The Contractor shall submit to the Division for review and approval prior to use its criteria for authorization or denial of payment for services rendered by Non-Contracted Providers. The Division shall review all such criteria for conformity with the Division's Policy for Claims Payment and must approve the criteria prior to implementation by the Contractor. The Contractor shall distribute its criteria for approval or denial of out-of-network services to all Non-Contracted Providers to whom Members are referred and shall distribute its criteria for approval of outside Emergency Services to all facilities providing Emergency Medical Services known to the Contractor and located within a thirty (30) mile radius of the Member's residence. All criteria shall be kept current.

The Contractor shall have written policies and procedures, in form and content acceptable to the Division, providing a mechanism for Providers to Appeal the denial of claims by the Contractor. If a claim is denied following completion of the Contractor's internal Appeals procedure, the Contractor shall provide written notice of the denial to the Provider and the Division. Notice to the Provider shall include a statement that the Provider may Appeal the determination to the Division; the procedure for submitting an Appeal to the Division; and any forms required for an Appeal. The Division shall make the final determination as to whether the Contractor is obligated to pay a claim and shall provide written notice to the Contractor and the Provider setting forth its determination. The Contractor shall pay each claim within thirty (30) calendar days following the date of each notice by the Division indicating that it has made a final determination requiring payment of the claim by the Contractor.

2. Payments for Provider-Preventable Conditions

The Contractor may not make payments for Provider-preventable conditions as

defined by the Federal regulations and the Mississippi State Plan in accordance with 42 C.F.R. § 438.6.

In accordance with the Mississippi State Plan, the Contractor shall identify and deny Never Events, which are a type of Provider-preventable condition. The Contractor shall track data and submit a report quarterly, in a format to be specified by the Division.

3. Payments from Members

Members utilizing medical services which are not medically necessary or who obtain covered services from Non-Contracted Providers without Prior Authorization and referral by the Contractor shall be responsible for payment in full of all costs associated with such services.

The Contractor shall not require any co-payments, deductibles or other cost sharing by Members for covered services under this Contract, nor shall the Contractor charge Members for missed appointments. Members with coverage from Third Party Liability/Resources shall not be required to pay any portion of the medical fees for covered services under this contract, even during the deductible periods of these other health plans.

The Member may be responsible for non-covered item(s) and/or service(s), only if, the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Member that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Member will be financially responsible for the item(s) and/or service(s).

K. **Physician Incentive Plans**

The Contractor may operate a physician incentive plan only if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to a Member. Contracts must comply with the requirements set forth in 42 C.F.R. § 422.208 and 422.210.

The Contractor shall provide to the Division of Medicaid the following disclosure annually or at the request of the Division of Medicaid:

1. Whether services not furnished by physician/group are covered by incentive plan. If the physician incentive plan does not cover services furnished by physician/group, no further disclosure is required;

2. The type of incentive arrangement (e.g. withhold, bonus, capitation);

3. Percentage of withhold or bonus, if applicable;

4. Panel size, and if patients are pooled, the approved method used; and

5. If the physician/group is at substantial financial risk, the Contractor must report proof the physician/group has adequate stop-loss coverage, including amount and type of stop-loss.

L. **Provider Discrimination**

Neither the Contractor, Subcontractor, nor representatives of Contractor shall provide false or misleading information to Providers in an attempt to recruit Providers for the Contractor's network. The Contractor shall not discriminate against Providers with respect to participation, reimbursement, or indemnification for any Provider acting within the scope of that Provider's license or certification under applicable State law or regulation solely on the basis of the Provider's license or certification.

The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely based on the license or certification. The Contractor shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. If the Contractor declines to include individual or groups of Providers in its network, it must provide the affected Providers written notice of the reason for its decision. Denials of Provider enrollment due to excess network capacity must receive Division approval prior to Provider notification. Nothing in this provision, however, shall preclude the Contractor from using reimbursement amounts greater than the Division's Fee-for-Service fee schedule for different specialties or for different practitioners in the same specialty, or preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members. The Contractor shall not employ or contract with Providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

SECTION 8 – CARE MANAGEMENT

A. Care Management Responsibilities

The Contractor is responsible for Care Management – a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care Management includes but is not limited to Continuity of Care, Transition of Care, and Discharge Planning.

The Contractor shall develop and implement a Care Management system to ensure and promote timely access and delivery of health care and services required by Members, continuity of Members' care, and coordination and integration of Members' care, including physical and Behavioral Health Services.

Within ninety (90) calendar days of contract award, the Contractor shall provide its overall approach to Care Management to the Division for review and approval. The Contractor shall revise its approach as requested by the Division, and will submit any

subsequent updates to the Division for approval.

1. Assignment of Risk Levels

   The Contractor shall develop a Care Management program that addresses the varying needs and differing levels of Care Management needs for Members. Based on the Health Risk Screening, the Contractor's Care Management program must provide for the completion of a detailed health risk assessment for Members, which includes an assessment of and assignment to risk stratification levels (e.g., low, medium, high) which determine the intensity of interventions and follow-up care that is required for each Member. The Contractor shall prioritize and assign Members to low, medium, or high levels based on the identified risk and level of need. Members who have high costs or potentially high costs or otherwise qualify, include but are not limited to pregnant women under twenty-one (21), high risk pregnancies, serious and persistent behavioral health conditions, and infants and toddlers with established risk for developmental delays, shall be assigned to the medium or high risk level and receive Care Management services. Members with less intensive needs will be assigned to the low risk level and shall have access to Care Management teams.

   The Care Manager must contact the Member via telephone or face-to-face interview to assess the Member's Care Management needs. This detailed health risk assessment must evaluate the Member's medical condition(s), including physical, behavioral, social and psychological needs. The goal of this assessment is to confirm the Member's need for Care Management, identify the Member's existing and /or potential health care needs, determine the types of services needed by the Member and begin the development of the treatment plan. The Contractor will determine the need for an onsite visit at the Member's residence to complete this assessment. This detailed health risk assessment must occur within thirty (30) calendar days for Members newly assigned to the High or Medium risk levels as a result of the Health Risk Screening, referral and/or predictive modeling.

   The detailed health risk assessment must be reviewed by a qualified health professional appropriate for the Member's health condition. The detailed health risk assessment shall address the following, at a minimum:

   a. Identification of the severity of the Member's conditions/disease state;

   b. Evaluation of co-morbidities, or multiple complex health care conditions;

   c. Demographic information (including ethnicity, education, living situation/housing, legal status, employment status; and

   d. The Member's current treatment Providers and treatment plan, if available.

   The treatment plan for the Member must be completed within thirty (30) days of the completion of the detailed health risk assessment, if appropriate.

   The Contractor shall conduct initial and ongoing predictive modeling to identify and

evaluate the Member's risk level, which must incorporate the use of pharmacy utilization data. In addition, in consideration of the fact complete claims data may not be available for the MississippiCAN population, particularly for Members new to the program, the Contractor must propose other analyses used to identify and stratify Members who may be in need of Care Management services. Whenever available, the Contractor shall use findings from an initial Health Risk Screening for new Members. The Contractor shall report on the number of Members for whom they attempted to conduct a Health Risk Screening, the number of Members who could not be reached, and the findings from the Health Risk Screenings for those Members whom the Contractor was able to assess. The Contractor shall report this information as part of the Care Management Reports.

Additionally, Members may be considered for receiving Care Management services, through Provider referral, State Agency referral and Member self-referral. At a minimum, the Contractor shall provide Care Management services to all Members identified with the following chronic conditions: diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.

Following the health risk assessment, the Contractor shall update the risk level assignment when there has been a change in the health status, needs, or a significant health care event relevant to the Member's risk level assignment.

The Contractor must receive Division approval for other analysis used to identify Member's risk level prior to use. The Contractor shall modify its approach upon Division request. Additionally, the Contractor shall provide alternate solutions if the implemented approach does not achieve the targeted outcomes and savings over time.

All Members shall have access to the Care Management Team and the Contractor must provide all Members with information on how to contact this Team through the Contractor Member Information Packet.

2. Care Management Services

Member information shall be maintained by the Contractor and accessible twenty-four (24) hours per day seven (7) days per week by members of the Care Management Team.

The Contractor must develop and adopt policies and procedures to ensure all Members have access to required services. At a minimum, Members shall have available the following services:

a. Assignment to a Care Management team: The Contractor must assign a point of contact for each Member. The Contractor shall assign Members in the high risk and medium risk categories to a specific Care Management team member;

b. Access to a Member services call center;

c. Assistance with care coordination and access to primary care, behavioral health, preventive and specialty care, as needed;

d. Coordination of discharge planning;

e. Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA),the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;

f. Developing, planning and assisting Members with information about community-based, free care initiatives and support groups;

g. Responding to Member clinical care decision inquiries in a manner that promotes Member self-direction and involvement;

h. When requested by individuals, identifying participating Providers, facilitating access and assisting with appointment scheduling when necessary;

i. Providing information about the availability of services and access to those services;

j. Working with Members and Providers to ensure continuity of care; and

k. Monitoring and following up with Members and Providers, which may include regular mailings, newsletters, or face-to-face meetings, as appropriate.

In addition, the Contractor must develop and adopt policies and procedures to address the following:

a. A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning, as appropriate;

b. Method for actively engaging Members in need of Care Management who are unresponsive to contact attempts or disengaged in Care Management;

c. An approach that uses pharmacy utilization data to tailor Care Management services;

d. Procedures and criteria for making referrals to specialists and sub-specialists;

e. Procedures and criteria for maintaining treatment plans and referral services when the Member changes PCPs;

f. Documentation of referral services and medically indicated follow-up care in each Member's Medical Record;

g. Documentation in each Medical Record of all Urgent Care, emergency encounters and any medically indicated follow-up care; and

h. Ensuring that when a Provider is no longer available through the Contractor, the Contractor allows Members who are undergoing an active course of treatment to access services from Non-Contracted Providers for sixty (60) calendar days.

Members identified as medium risk or high risk will be assigned a Care Manager.

The Contractor shall provide Members assigned to the medium risk level all services included in the low risk level and the following services, at a minimum:

a. Facilitate relapse prevention plans for Members with depression and other high-risk behavioral health conditions and their PCPs/Community Mental Health Centers (e.g., patient education, extra clinic visits, and follow-up phone calls);

b. Partner with Provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence;

c. Educate Provider office staff about symptoms of exacerbations and how to communicate with patient;

d. Develop speaking points and triggers for making emergency appointments; and

e. Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors or unmet needs.

The Contractor shall provide Members assigned to the high risk level all the services included in the low risk and medium risk levels and the following services, at a minimum:

a. As appropriate, form inter-disciplinary treatment teams to assist with development and implementation of individual medical treatment plans;

b. Provide list of community resources (for referral) including Medicaid PCPs, Certified Diabetic Educators, free exercise classes, nutritional support, etc.;

c. Identify Providers with special accommodations (e.g., sedation dentistry);

d. Educate staff about barriers Members experience in making and keeping appointments;

e. Facilitate group visits to encourage self-management of various physical and behavioral health conditions/diagnoses such as pregnancy, diabetes and tobacco use; and

f. Communicate on a patient-by-patient basis on gaps/needs to assure patient has baseline and periodic medical evaluations from the PCP.

3. Perinatal High Risk Management/Infant Services System

The Contractor shall coordinate with the Mississippi State Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS). The Contractor will work with MSDH to identify Members who meet the Program criteria. MSDH will provide case management services to those Members, and the Contractor will coordinate with MSDH to confirm the case manager will support all of the Members' health care needs. Should the Members have additional needs, the Contractor will provide additional case management and coordinate with the MSDH case managers to create an individual medical treatment plan for the Members. The Contractor shall immediately refer high risk pregnant women meeting PHRM/ISS Program criteria for case management to the MSDH. The Contractor will coordinate with the MSDH, as specified by the Division.

4. Continuity of Care

When Members disenroll from the Contractor, the Contractor is responsible for transferring to the Division the Member's Care Management history, six (6) months of claims history, and pertinent information related to any special needs of transitioning Members. The Contractor, when receiving a transitioning Member with special needs, is responsible to coordinate care with the Contractor from which the Member is disenrolling so that services are not interrupted, and for providing the new Member with service information, emergency numbers, and instructions on how to obtain services.

5. Reporting

The Contractor will submit quarterly reports to the Division that include specified Care Management program data as described in Section 10, Reporting Requirements, and Exhibit H, Reporting Requirements, of this Contract. The Division will request cases to review for appropriateness in terms of assignments to risk levels, treatment plans, and discharge planning, at its discretion.

The Contractor shall submit a report on its activities related to coordinating with the MSDH on PHRM/ISS and providing additional case management to identified Members in a format to be specified by the Division.

B. <u>Discharge Planning</u>

The Contractor shall maintain and operate a formalized discharge planning program that includes a comprehensive evaluation of the Member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting. This includes outpatient and inpatient hospital services. The Contractor's discharge planning process will include how the Contractor will work

and coordinate with the Division or Division's Agent for inpatient care to facilitate the Contractor's discharge planning.

SECTION 9 – QUALITY MANAGEMENT

The Contractor must submit reports related to quality management in accordance with Section 10, Reporting Requirements, Exhibit G, Quality Management, and Exhibit H, Reporting Requirements, of this Contract.

A. General Requirements

The Contractor shall support and comply with the MississippiCAN Quality Strategy, including all reporting requirements in formats to be determined by the Division.

The Contractor shall comply with the MississippiCAN Quality Management (QM) requirements to improve the health outcomes for all Members. Improved health outcomes will be documented using established Performance Measures.

The Contractor shall implement and maintain a QM program as described below. The Division retains the right of advance written approval and to review on an ongoing basis all aspects of the Contractor's QM program, including subsequent changes.

The Division, in collaboration with the Contractor, retains the right to determine and prioritize QM activities and initiatives based on areas of importance to the Division and CMS.

The Contractor shall participate and shall recruit network Providers to participate in the MississippiCAN Quality Leadership Team as defined in Table 7 below.

Table 7. MississippiCAN Program Quality Committees

Quality Committee	Committee Membership
MississippiCAN Quality Leadership Team	• Medical Directors of each of the CCOs • Other CCO Executives, as designated by the Division • Other representatives, as determined by the Division • At least two (2) network Providers from each CCO who are actively involved in providing services to Members • Members receiving MississippiCAN services, to be determined by the Contractor

Quality Committee	Committee Membership
	• Division Staff
MississippiCAN Quality Task Force	• MississippiCAN CCOs, including the Quality Managers and Health Services Managers • Quality Managers and Health Services Managers from the behavioral health subsidiary • Division Staff

B. Accreditation

At a minimum, the Contractor shall achieve interim accreditation by the National Committee for Quality Assurance (NCQA) for MCOs by year two of this Contract. At a minimum, the Contractor shall achieve full accreditation by the NCQA for MCOs by year three of this Contract. The Contractor shall provide to the Division upon request any and all documents related to achieving such accreditation and the Division shall monitor the Contractor's progress towards accreditation.

C. External Quality Review

On at least an annual basis, the Contractor will cooperate fully with any external evaluations and assessments of its performance authorized by the Division under this Agreement and conducted by the Division's contracted External Quality Review Organization (EQRO) or other designee. Independent assessments will include, but not be limited to, any independent evaluation required or allowed by Federal or State statute or regulation. See Exhibit B, External Quality Review, of this Contract for additional requirements of the Contractor.

The Contractor shall address any deficiencies or contract variances identified by the External Quality Review Organization (EQRO) expediently, on a schedule to be determined by the Division. The Division may issue sanctions for deficiencies or contract variances, which are not addressed to the satisfaction of the Division.

D. Quality Management System and Quality Improvement Program

The Contractor shall implement and operate an internal quality management (QM) system and quality improvement (QI) program in compliance with 42 C.F.R. § 438.240 which:

1. Provides for review by appropriate health professionals of the process followed in providing covered services to Members;

2. Provides for systematic data collection of performance and patient outcomes;

3. Provides for interpretation and dissemination of performance and outcome data to contracted Providers and Non-Contracted Providers approved for referrals for primary and specialty;

4. Provides for the prompt implementation of modifications to the Contractor's policies, procedures and/or processes for the delivery of covered services as may be indicated by the foregoing;

5. Provides for the maintenance of sufficient encounter data to identify each practitioner providing services to Members, specifically including the unique physician identifier for each physician; and

6. Complies with Miss. Code Ann. § 83-41-313 et. seq. (1972, as amended), of the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plan Protection Act and Miss. Code Ann. § 83-41-409 (1972, as amended) of the Patient Protection Act of 1995.

The Contractor will have a written description of the QM program that focuses on health outcomes and that includes the following:

1. A written program description including an Annual QM Program Work Plan; detailed objectives, accountabilities and time frames; definition of the scope of the QM program, and an Annual Program Evaluation. Detailed requirements are included in Exhibit G, Quality Management, of this Contract.

2. A work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, consistent with the clinical Performance Measures and targets put forth by the Division, including, but not limited to:

    a. Data collection and analysis;

    b. Evaluation and reporting of findings;

    c. Implementation of improvement actions where applicable; and

    d. Individual accountability for each activity.

3. Composition of the QM committee including a physical and behavioral health Provider.

4. Procedures for remedial action when deficiencies are identified.

5. Specific types of problems requiring corrective action.

6. Provisions for monitoring and evaluating corrective action to ensure that actions for improvement have been effective.

7. Procedures for Provider review and feedback on results.

8. Annual performance evaluation of the QM program as part of the Internal Audit that includes:

    a. Description of completed and ongoing QM activities including Care Management effectiveness evaluation;

    b. Identified issues, including tracking of issues over time;

    c. Trending of measures to assess performance in quality of clinical care and quality of service to Members; and

    d. An analysis of whether there have been demonstrated improvements in Members' health outcomes, the quality of clinical care and quality of service to Members; and overall effectiveness of the QM program (e.g., improved HEDIS® scores).

9. The Contractor must have in effect mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs.

10. The Contractor must address health care disparities.

The Contractor will submit a copy of Annual Program Description, Annual Program Evaluation and Annual Work Plan to the Division annually for review and approval. The QM program description, including the Annual Work Plan, will be submitted to the Division for written approval annually. The Contractor will also submit regular quarterly work plan updates to the Division. The Division reserves the right to expand the QM Program as needed to assure quality Member care.

The Contractor will make available to its Members and Providers information about the QM program and a report on the Contractor's progress in meeting its goal annually. This information must be reviewed and approved by the Division prior to distribution.

E. Performance Measures

The Contractor shall comply with the Division's Quality Management requirements to improve the health outcomes for all Members. The Contractor shall meet specific performance targets, as outlined in Exhibit F, Performance Measures, of this Contract for each of the Performance Measures identified by the Division.

The Division may update performance targets, include additional Performance Measures or remove Performance Measures from the list of required Performance Measures and required targets at any time during the contract period. The Division and the Contractor(s) shall have an ongoing collaborative process on the development, addition, and modification of Performance Measures and setting of performance targets to identify opportunities for improving health outcomes.

Many of the MississippiCAN Performance Measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS®). The Contractor shall use the standardized methodology as outlined in Volume 2, HEDIS® Technical Specifications,[1] to calculate its performance rates. The Contractor shall contract with a Certified HEDIS® Audit Firm to conduct a certified audit of its HEDIS® rates, and shall report the findings of that audit, including the actual report submitted by the auditor to NCQA, to the Division. The Contractor shall report rates for all Performance Measures to the Division, regardless of whether they are based on HEDIS® technical specifications.

While the Contractor must meet the Division Performance Measure Targets for each measure, it is equally important that the Contractor continually improve health outcomes from year to year. The Contractor shall strive to meet the Performance Measure targets established by the Division.

The Division reserves the right to make any HEDIS® and Performance Measures results public.

F. CAHPS® Member Satisfaction Survey

The Contractor shall contract with an NCQA certified survey vendor to administer an annual CAHPS® Member Survey. The results of the survey and action plans derived from these results must be filed with the Division at least ninety (90) calendar days following the Contractor's receipt of the survey findings from its certified survey vendor.

The Division reserves the right to make any CAHPS® Member Survey and results public.

G. Provider Satisfaction Survey

The Contractor shall conduct annual Provider satisfaction surveys. The Contractor must submit to the Division for review and approval, the survey questions and methodology by March 1 for the current calendar year. The results of the survey and action plans derived from these results must be filed with the Division at least ninety (90) calendar days following the completion of the survey and no later than December 1 for the current calendar year.

H. Value-Based Purchasing

At its option, the Division may implement a value-based purchasing within the

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[1] NCQA publishes the Technical Specifications annually to assist in the calculation of HEDIS® measures. Contractors shall use the version, which represents the reporting year for HEDIS® rates (e.g., health plans report calendar year 2013 rates in 2014 based on Volume 2-2014 Technical Specifications).

MississippiCAN Program. The Division reserves the right to phase in implementation of a value-based purchasing model beginning with a performance incentive program. Should the Division move forward with such an effort, the Division will provide operational protocols describing the process for selecting priority areas, measures, and targets, Contractor expectations, and Division responsibilities prior to implementation. If implemented, the value-based purchasing model will require the participation of key Contractor staff, including the Medical Director, in regular meetings with Division staff. The value-based purchasing model may lead to the creation of subcommittees to current MississippiCAN Program Quality Committees, referenced in Section 9.A, General Requirements, of this Contract.

The Contractor will have an opportunity to provide recommendations on selections for priority areas, measures, and targets based on the results of gaps analysis and root cause analyses performed by the Contractor. The Division will have final authority on the selection of priority areas, measures, and targets, which the Contractor will be required to comply.

I. Performance Improvement Projects

The Contractor shall also perform a minimum of four (4), either clinical or non-clinical Performance Improvement Projects (PIP) each year on topics prevalent and significant to the population served. PIPs shall meet all relevant CMS requirements. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. The Contractor shall:

1. Show that the selected area evaluation is based on a demonstration of need and is expected to achieve measurable benefit to the Member (rationale);

2. Establish clear, defined and measurable goals and objectives that the Contractor shall achieve in each year of the project;

3. Measure performance using Quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time;

4. Implement interventions designed to achieve Quality improvements;

5. Evaluate the effectiveness of the interventions;

6. Establish standardized Performance Measures (such as HEDIS® or another similarly standardized product);

7. Plan and initiate activities for increasing or sustaining improvement; and

8. Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.

Due to the critical importance of the area of obesity to the Medicaid population, this area should be selected annually for study providing continuous evaluation. At least three (3)

other clinical or health service delivery areas completing the required total of four (4) should be selected annually for quality improvement activities. The Division will pre-approve all PIPs. The Division may require the Contractor to implement PIPs focusing on specified conditions. The Contractor will include study question and study indicators agreed upon by the Division and the Contractor.

The Contractor shall include information on PIPs in the Quality Management program description and work plan submitted to the Division.

In addition to those set forth herein, CMS, in consultation with the State, and other stakeholders, may specify additional Performance Measures and topics for PIPs to be undertaken by the Contractor.

J. Disenrollment Survey

The Contractor shall outreach to Members who disenroll from the Contractor to determine the reason for their Disenrollment. The Contractor must administer Disenrollment surveys to Members via phone or mail within five (5) business days of the Member disenrolling from the Contractor. The Contractor must submit to the Division for review and approval, the survey questions and methodology.

The Contractor shall report findings from the Disenrollment survey and a work plan for addressing results of the Disenrollment survey on a quarterly basis to the Division.

K. Quality Management Committee

The Contractor must operate under a formal organizational structure for the implementation and oversight of the internal quality management program. The formal organizational structure must include at a minimum, the following:

1. Established parameters of operation including specifics regarding role, function and structure;

2. A designated health care practitioner, qualified by training and experience, to serve as the QM Director;

3. A committee which includes representatives from the Provider groups as well as clinical and non-clinical areas of the organization;

4. A senior executive who is responsible for program implementation;

5. Substantial involvement in QM activities by the Contractor's Medical Director;

6. QM activities must be distinctly separate from the Utilization Review activities and the distinction must be well defined;

7. The QM committee must meet regularly with specified frequency to oversee QM activities. This frequency will be sufficient to demonstrate that the committee is

following up on all findings and required actions, but in no case are such meetings to be less frequent than quarterly;

8. Records that document the committee's activities, findings, recommendations, actions, and results; and

9. Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.

L. Standards

The QM Program shall provide continuous performance of quality of care studies, health service delivery studies and other monitoring activities using objective, measurable and current standards for service delivery, quality indicators, or pre-established practice guidelines.

M. Clinical Practice Guidelines

The Contractor shall develop and make available to Providers clinical practice guidelines consistent with national standards for disease and chronic illness management of Members. These clinical practice guidelines shall be based on reasonable scientific evidence, reasonable medical evidence, reviewed annually by Contracted Providers who can recommend adoption of clinical practice guidelines to the Contractor, and communicated to those whose performance will be measured against them. Clinical guidelines are provided by the Contractor to physicians and other Contracted Providers as appropriate. The Contractor reviews the guidelines at least every two (2) years and updates them as appropriate.

The Contractor, on an annual basis, shall measure Provider performance against at least two (2) of the clinical guidelines and provide the Division the results of the study and a summary of any corrective actions taken to ensure compliance with the guidelines.

N. Utilization Review

The Contractor will provide for a system of utilization review consistent with the requirements of 42 C.F.R. Part 456 and in accordance with Miss. Code Ann. § 41-83-1 et. seq. and other applicable sections (1972, as amended).

The Contractor shall have a written Utilization Review Program description which outlines the program structure and accountability and includes, at a minimum:

1. Criteria and procedures for the evaluation of medical necessity of medical services for Members;

2. Criteria and procedures for pre-authorization and referral that include Appeal mechanisms for Providers and Members;

3. Mechanisms to detect and document underutilization as well as over utilization of

medical services;

4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs;

5. Availability of utilization review criteria to Providers;

6. Involvement of actively practicing, board certified physicians in the program to supervise all review decisions and to review denials for medical appropriateness;

7. Availability of physician reviewer to discuss determinations by telephone with physicians who request such;

8. Evaluation of new medical technologies and new application of existing technologies and criteria for use by contracted Providers;

9. Annual utilization review program review to determine effectiveness and need for changes;

10. Process for measuring Provider performance against at least two (2) of the clinical guidelines on an annual basis;

11. Process and procedure to address disparities in health care, which shall be in included in the Quality Improvement Work Plan;

12. A process for identifying clinical issues and analyzing the issues by appropriate clinicians and, when appropriate, developing corrective action taken to improve services;

13. Development of disease management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants; and

14. A comprehensive health education program that will support the Care Management programs.

The Contractor shall annually evaluate its UM program and submit a copy of this evaluation to the Division annually. The UM program description will be submitted to the Division for written approval annually.

The Contractor shall provide utilization review criteria to Providers upon request.

O. Internal Audit and Report

The Contractor shall semi-annually review, evaluate, and modify, as necessary, the quality management system, including the Medical Record system, data collection system and system for checking Provider credentials, as well as all quality management policies and procedures, Grievance procedures, clinical care standards, practice

guidelines, Member utilization, access to covered services, and treatment outcomes. The Contractor shall submit a report to the Division, detailing the semi-annual review, completed activities and corrective actions, corrective actions which are recommended or in progress, and the results of all clinical, administrative and Member satisfaction surveys conducted during the immediately preceding year. The report shall set forth any proposed modifications to the quality management system or policies and procedures. Any such modifications shall be approved in writing by the Division prior to implementation.

P. Medical Audit

The Division may conduct annual medical audits of the Contractor during which the Division will identify and collect management data including information on the use of services and Enrollment and Disenrollment policies to ensure that the Contractor furnishes quality and accessible health care to enrolled Members. The Division will review any of the Contractor's policies and procedures for compliance with the terms of this Contract and any policies and procedures for services.

Q. EPSDT Audit

In conjunction with the medical audit, complete EPSDT claims data for the Contractor and a sample of Medical Records will be evaluated by the Division annually to determine compliance by the Contractor with the requirements of this Contract for provision of EPSDT Services to Members under age twenty-one (21). Requirements will be based on the EPSDT 416 report.

The Contractor must achieve the screening rates in Table 8 to comply with this Contract. The identified targets are in effect for the first year of operations, and the Division will update these targets annually.

Table 8. EPSDT Screening Rates

Measure	Screening Rate Targets
Screenings	Eighty-five percent (85%) of children enrolled had required screenings
Immunizations	Ninety percent (90%) of children enrolled had required immunizations

The screening rate will be calculated using the reportable number for Line 7-Screening Ratio of the EPSDT 416 report. To calculate the screening rate, the Division shall divide the actual number of initial and periodic screening services received (line 6 of 416 report) by the expected number of initial and periodic screening services (line 5 of 416 report). This ratio indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by the State's periodicity schedule prorated by the portion of the year for which they are Medicaid eligible. For a child who has been enrolled from birth through twelve (12) months, compliance with the EPSDT

periodicity schedule is six (6) screens. Immunization compliance means that the child is up-to-date with his/her immunizations based on the Advisory Committee on Immunization Practices (ACIP) immunization schedule.

The Contractor shall publish screening rates in required educational and marketing presentations to potential Members.

The Contractor will be subject to sanctions if it does not achieve the targets specified in Table 8, in accordance with Section 15, Default and Termination, of this Contract.

R. <u>Readiness Reviews</u>

The Contractor shall comply with all requirements related to the assessment of the Contractor's performance prior to implementation, as required by the Request for Proposals. The Division will complete readiness reviews of the Contractor prior to implementation of MississippiCAN Program expansions and contract renewals at its discretion. This includes evaluation of all program components including information technology, administrative services, Provider Network management and medical management. The readiness reviews will include desk reviews of materials the Contractor must develop and onsite visits at the Contractor's administrative offices. The Division may also conduct onsite visits to any Subcontractor's offices.

1. Non-Emergency Transportation (NET) Services

   As part of the readiness review, the Contractor shall submit a final Quality Assurance Plan for NET services to the Division for its review and approval. The Quality Assurance Plan shall include at least the following:

   a. The Contractor's procedures for certification that all NET services paid for are properly authorized and actually rendered;

   b. The Contractor's plan to develop safeguards against Fraud or Abuse by NET Providers, Medical Providers, Members and Contractor staff and fulfill the Division's reporting requirements regarding such activity;

   c. The Contractor's agreement to indemnify the Division against any causes of actions or claims of payment brought by NET Providers or Members; and

   d. The Contractor's plan to ensure that NET Providers meet standards for vehicle maintenance, operation, and inspection; driver qualifications and training; Complaint resolution; and delivery of courteous, safe and timely NET services.

SECTION 10 – REPORTING REQUIREMENTS

The Division reserves the right to make operational reports, data, and information submitted by the Contractor public. The Division also reserves the right to perform audits, as appropriate, to verify and validate operational reports, data, and information submitted by the Contractor.

A. Record System Requirements

The Contractor shall maintain detailed records evidencing all expenses incurred pursuant to this Contract; Member Enrollment status; provision of covered services; Complaints; and all relevant medical information relating to individual Members, for the purpose of audit and evaluation by the Division and other Federal or State agencies. All records, including training records, pertaining to the Contract, shall be maintained and available for review by authorized Federal and State agencies during the entire term of this Contract and for a period of five (5) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit is in progress, audit findings are unresolved, or there is pending litigation that has not been completed, records shall be kept for a period of five (5) years or until all issues are finally resolved, whichever is later. All records shall be maintained at one central office in Mississippi designated by the Contractor and approved by the Division**.**

All records, including training records, pertaining to the Contract must be readily retrievable within three (3) business days for review at the request of the Division and its authorized representatives at no cost to the Division or its authorized representatives.

Related to QM activities, the Contractor shall maintain and make available to the Division, CMS, Office of Inspector General (OIG), the State Medicaid Fraud Control Unit, and State and Federal Auditors, all studies, reports, protocols, standards, work plans, work sheets, committee minutes, committee reports to the Board of Directors, Medical Records, and such further documentation as may be required by the Division, concerning quality management activities and corrective actions.

B. Reporting Requirements

The Contractor is responsible for complying with the reporting requirements set forth in this Section, and for assuring the accuracy, completeness and timely submission of each report. The Contractor shall provide such additional data and reports as may be requested by the Division. On or before May 1, 2014, the Division will furnish the Contractor with the appropriate reporting formats, instructions, and timetables for submission. The Division will also provide technical assistance in filing reports and data as may be permitted by the Division's available resources. The Division reserves the right to modify from time to time the form, content, instructions and timetables for the collection and reporting of data. The Division will provide the Contractor with written notice of such modifications. Modifications will be effective no earlier than sixty (60) days from the date on the written notice provided to the Contractor.

The Contractor shall transmit and receive all transactions and code sets required by the Health Insurance Portability and Accountability Act (HIPAA) regulations, as required by Section 16.A, HIPAA Compliance, of this Contract.

The Contractor shall submit to the Division copies of all reports submitted to the Mississippi Department of Insurance.

The Contractor agrees to furnish to the Division, at no cost to the Division, any records,

documents, reports, or data generated or required in the performance of this contract including, but not limited to, the reports specified in Exhibit H, Reporting Requirements, of this Contract.

C. Enrollment Reports

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

D. Member Identification Card Reports

The Contractor shall submit a monthly report of returned identification cards. The report must identify all returned cards, with the Member's Mississippi Medicaid identification number, first/last name, incorrect address, and correct address, if available.

E. Provider Services Reports

The Contractor shall submit a quarterly report providing information on general Provider services operations, including but not limited to Provider credentialing and recredentialing, Provider enrollment, Provider services call center, staff training, and Complaints, Grievances, and Appeals.

F. EPSDT Reports

The Contractor shall comply with all requirements related to the submission of an EPSDT 416 report as required by the Federal government. The Contractor will have in place a periodic notification system that will facilitate compliance with the EPSDT periodicity schedule. This report must be submitted annually for the Division to comply with Federal requirements.

The Contractor shall submit quarterly reports with EPSDT 416 measures to the Division.

G. Medical Records

The Contractor shall ensure the maintenance of current, detailed, organized Medical Records by health care Providers for each Member sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed pursuant to this Contract. Medical records shall be accessible and made available to Providers providing services to Members enrolled with the Contractor, and to the Division for purposes of Medical Record review. The Contractor shall follow applicable policies and procedures in

accordance with Division Administrative Code.

H. Financial Reports

The Contractor shall file with the Division, within seven (7) calendar days after issuance, a true, correct and complete copy of any report or notice issued in connection with a financial examination conducted by or on behalf of the Department of Insurance, State of Mississippi.

The Contractor shall submit to the Division a copy of all quarterly and annual filings submitted to the Department of Insurance. A copy of such filing shall be submitted to the Division on the same day on which it is submitted to the Department of Insurance. Any revisions to a quarterly and/or annual Department of Insurance financial statement shall be submitted to the Division on the same day on which it is submitted to the DOI.

Throughout the duration of the Contract term, the Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor shall enhance or update it upon request. Throughout the term of the Contract, the Contractor must notify the Division prior to making any changes to its basis of accounting.

The Department of Insurance regulates the financial stability of all appropriately licensed Contractors in Mississippi. The Contractor agrees to comply with all DOI standards.

The Contractor shall file with the Division other financial reporting as required for the Capitation Payment development process.

I. Third Party Liability Audit

The Division or its designated Agent shall periodically, at least annually, conduct a Third Party Liability audit of the Contractor. The Contractor shall make available specific data as requested to complete the audit.

J. Third Party Liability Reporting

The Contractor shall provide a monthly report to the Division that includes, at a minimum, the Member's name, Medicaid Identification Number, date of accident, lien amount and third party's name and contact information by the thirtieth (30th) of each month. Medicaid's third party unit will review the monthly report and inform the Contractor whether or not Medicaid has a claim for services relating to the date of accident. In such cases, the Contractor will work closely with the Division to coordinate efforts.

For cases identified by the Division as having a separate claim for medical services, the Division has the right to request the Contractor submit related information for the

Division's review within three (3) business days of the request.

K. Contractor Member Complaints, Grievances, and Appeal Reporting

The Contractor shall maintain a health information system to track the receipt and resolution of verbal, in-person, and written Complaints, Grievances, and Appeals. The Contractor shall submit to the Division by the fifteenth (15th) business day of the month after the end of each month, a mutually agreed upon summary report of all Provider and Member Complaints, Grievances, and Appeals as illustrated in this contract. The system and the tracking logs shall be made accessible to the Division for review.

The Contractor shall also submit to the Division by the fifteenth (15th) day of the month after the end of each month a detailed log of all Member Grievances and Appeals and all Provider Complaints, Grievances and Appeals made on behalf of a Member under this Contract.

1. Grievance and Complaint categories identified shall be organized or grouped by the following general guidelines:

    a. Transportation;

    b. Access to Services/Providers;

    c. Provider Care and Treatment;

    d. Contractor Customer Service;

    e. Payment and Reimbursement Issues; and

    f. Administrative Issues.

2. Appeal categories identified shall be organized or grouped by the following general guidelines:

    a. Transportation;

    b. Contractor Administrative Issues; and

    c. Benefit Denial or Limitation.

3. The log shall contain the following information for each Complaint, Grievance or Appeal:

    a. The date of the communication;

    b. The Member's Mississippi Medicaid identification number;

    c. Whether the Complaint, Grievance or Appeal was written or verbal;

d. Indication of whether the dissatisfaction was a Complaint, Grievance or an Appeal;

e. The category, specified in subsection 1, of each inquiry;

f. A description of subcategories or specific reason codes for each Complaint, Grievance and Appeal;

g. The resolution (detailed information about how the Complaint, Grievance or Appeal was resolved); and

h. The resolution date.

The Contractor shall submit to the Division within thirty (30) calendar days of filing a copy of any report regarding specific Complaints, Grievances, or Appeals or its system for tracking Complaints, Grievances and Appeals required to be filed with the Mississippi Department of Insurance.

L. <u>Confidentiality of Records</u>

The Contractor shall treat all information, including that relating to Members and Providers, which is obtained by the Contractor through its performance under this Contract as confidential information and shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights hereunder.

All information as to personal facts and circumstances concerning Members obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the Division and the written consent of the Member, his/her attorney, or his/her responsible parent or guardian, except as may be required by the Division. The use or disclosure of information concerning Members shall be limited to purposes directly connected with the administration of the contract. All of the Contractor officers and employees performing any work for or on the contract shall be instructed in writing of this confidentiality requirement and required to sign such a document upon employment and annually thereafter.

The Contractor shall immediately notify the Division of any unauthorized possession, use, knowledge or attempt thereof, of the Division's data files or other confidential information. The Contractor shall immediately furnish the Division full details of the attempted unauthorized possession, use or knowledge, and assist in investigating or preventing the recurrence thereof.

The Division, the State Attorney General, authorized Federal or State personnel or the authorized representatives of these parties, including, without limitation, any employee, Agent, or Contractor of the Division, CMS, and the Division's Agent, shall have access to all confidential information in accordance with the requirements of this Contract and State and Federal law and regulations pertaining to such access. The Division shall have

authority to determine if and when any other party has properly obtained the right to have access to such information in accordance with applicable State and Federal laws and regulations. The Contractor shall adhere to 42 C.F.R., Part 431, Subpart F and 45 C.F.R. Parts 160 and 164, Subparts A and E to the extent these requirements are applicable to the obligations under this Contract.

M. <u>Access to Records</u>

Pursuant to the requirements of Title XIX, Section 1902(a)(27) of the Social Security Act, 42 C.F.R. § 434.6(a)(5) and 42 C.F.R. § 438.6, Section 1128A [42 U.S.C. 1320a-7a] and Miss. Code Ann. § 43-13-118,121,229 (1972, as amended), the Contractor and each of its Providers shall make all of its books, documents, papers, Provider records, Medical Records, financial records, data, surveys and computer databases (collectively referred to as records) available for examination and audit by the Division, the State Attorney General, authorized Federal or State personnel or the authorized representatives of these parties including, without limitation, any employee, Agent, or Contractor of the Division, CMS, and the Division's Agent. Access will be at the discretion of the requesting authority and will be either through on-site review of records or by submission of records to the office of the requester. Any records requested hereunder shall be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) calendar days following a request, for desk audits. Requests may be written or verbal. All records shall be provided at the sole cost and expense of the Contractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Division shall have unlimited rights to use, disclose, and duplicate, all information and data developed, derived, documented, or furnished by the Contractor and in any way relating to this Contract in accordance with applicable State and Federal laws and regulations.

In accordance with 45 C.F.R. Section § 74.48, the Contract awarded to the Contractor and their Contractors shall make available to the HHS awarding agency, the U. S. Comptroller General, or any representatives, access to any books, documents, papers, and records of the Contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions. HHS awarding agencies, the HHS Inspector General, the U.S. Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of Contractor that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as records are retained.

There will be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

Any person (including an organization, agency or other entity, but excluding a Member)

that fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations or other statutory functions of the Inspector General of the Department of Health and Human Services, the Division, or any other duly authorized representative, shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of $15,000 for each day of the failure to make accessible all books, documents, papers, Provider records, Medical Records, financial records, data, surveys and computer databases (collectively referred to as records). In addition, the Division may make a determination to terminate the contract.

N. Health Information System

The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, Grievances and Appeals, and Disenrollment for other than loss of Medicaid eligibility. The Contractor must collect data on Member and Provider characteristics (i.e., trimester of Enrollment, tracking of appointments kept and not kept, place of service, Provider type), and make all collected data available to the Division**,** to CMS, to the Mississippi Department of Insurance, and to any other oversight agency of the Division.

O. Encounter Data

The Contractor must submit complete, accurate and timely encounter data to the Division that meets Federal requirements and allows the Division to monitor the program. Encounter Data consists of a separate record each time a Member has an Encounter with a health care Provider. A service rendered under this Agreement is considered an Encounter regardless of whether or not it has an associated Claim. The Contractor shall only submit Encounter Data for Members enrolled with the Contractor on date of service and not submit any duplicate records. The Provider's National Provider Identifier (NPI) shall be used when submitting required Encounter Data.

The Contractor is required to submit encounter data directly to the Division's Agent.

The Contractor must maintain appropriate systems and mechanisms to obtain all necessary data from its Providers to ensure its ability to comply with the Encounter Data reporting requirements. The failure of a Provider or Subcontractor to provide the Contractor with necessary encounter data shall not excuse the Contractor's non-compliance with this requirement.

The Contractor will be given a minimum of sixty (60) calendar days notification of any new edits or changes that the Division intends to implement regarding encounter data.

1. Data Format

The Contractor must submit Encounter Data to the Division's Agent using established protocols.

Encounter Data files must be provided in the following HIPAA transactions:

a. 837 Professional;

b. 837P Drug;

c. 837 Institutional;

d. 837 Dental; and

e. NCPDP batch files.

2. Provider Claims

The Contractor shall encourage Providers to submit claims as soon as possible after the dates of service. Providers shall be provided a minimum of ninety (90) calendar days and a maximum of six (6) months to submit claims from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial.

Claims adjudicated by a third party vendor must be provided to the Contractor by the end of the month following the month of adjudication.

The Division may impose penalties under Section 15, Default and Termination, of this Contract for non-compliance with these requirements.

3. Encounter Submissions

All Encounter records must be submitted by the Contractor and determined acceptable by the Division's Agent on or before the last calendar day of the third month after the payment/adjudication calendar month in which the Contractor paid/adjudicated the Claim. The Contractor shall submit the encounter data to the Division on a weekly basis.

Encounter records sent to the Division's Agent by the Contractor are considered acceptable when they pass all the Division's Agent's edits.

Encounter records that deny or suspend due to Division's Agent's edits are returned to the Contractor and the Contractor must make the requested corrections. The Contractor shall resubmit denied Encounter records as a "new" Encounter record if appropriate and within the time frame referenced above.

The Contractor shall correct and resubmit suspended Encounter records as an adjustment within the time frame referenced above. Corrections and resubmissions must pass all edits before they are accepted by the Division's Agent.

Failure of Subcontractors to submit Encounter Data timely shall not excuse the Contractor noncompliance with this requirement, and the Division may impose penalties under Section 15, Default and Terminations, of this Contract for non-compliance.

4. Encounter File Specifications

   The Contractor must adhere to the file size and format specifications provided by the Division. The Contractor must also adhere to the Encounter file submission schedule provided by the Division.

5. Data Completeness

   The Contractor shall submit records each time a Member has an Encounter with a health care Provider. The Contractor must have a data completeness monitoring program in place that:

   a. Demonstrates that all Claims and Encounters submitted to the Contractor by Providers and Subcontractors are submitted accurately and timely as Encounters to the Division's Agent. In addition, demonstrates that denied Encounters are resolved and/or resubmitted;

   b. Evaluates Provider and Subcontractor compliance with contractual reporting requirements; and

   c. Demonstrates the Contractor has processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with Encounter Data reporting to the Division.

   The Contractor must submit an annual Data Completeness Plan for review and approval. This Data Completeness Plan must include the three (3) elements listed above. The Contractor must report findings from its annual Data Completeness internal audits on at least an annual basis, or at the request of the Division.

6. Data Validation

   The Contractor agrees to assist the Division in its validation of Encounter Data by making available Medical Records and claims data as requested. The validation may be completed by the Division staff and/or independent, external review organizations.

   In addition, the Contractor will validate files sent to them when requested.

7. Secondary Release of Encounter Data

   All Encounter Data recorded to document services rendered to Members under this Agreement are the property of the Division. Access to this data is provided to the Contractor and its agents for the sole purpose of operating the MississippiCAN

Program under this Agreement. The Contractor and its agents are prohibited from releasing any data resulting from this Agreement to any third party without the advance written approval of the Division.

The Division will impose penalties and/or sanctions under Section 15, Default and Terminations, of this Contract for any encounter data not received monthly or in cases that the data does not meet the Division's requirements.

P. Drug Utilization Data

The Contractor shall report drug (i.e., j-code) utilization data to the Division's Agent as authorized by the Omnibus Budget Reconciliation Act of 1990, Section 1927 of the Social Security Act, and as required by CMS for the purposes of accurate, timely collection of quarterly drug rebates. The Contractor must include national drug code (NDCs) numbers and corresponding quantities (i.e., HCPCS units for physician/ outpatient physician-administered drugs) in a format to be specified by the Division. The Contractor shall submit to the Division the drug utilization data necessary for the collection of drug rebates in formats to be specified by the Division weekly. The Contractor must resolve any disputes related to the data within sixty (60) calendar days from notification of the Division.

Q. Data Certifications

All data, reports, documents, records, encounter data, and any other information required to be submitted to the Division by the Contractor shall be certified by one of the following: the Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports to, the Contractor's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the data and to the accuracy completeness and truthfulness of the documents. The Contractor must submit the certification in writing with the signature of the appropriate certifier, at the time the certified data, documents, reports, records, encounter data, or other information is submitted to the Division.

R. Claims Processing and Information Retrieval Systems

The Contractor's claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements identified in this Contract.

The Contractors' claims processing and information retrieval systems must be in compliance with all components of 42 C.F.R. § 433.116.

The Contractor's claims processing and information retrieval systems must have the capability to accept claims history data from the Division or its Agent.

S. Fraud and Abuse Reporting

The Contractor shall report Member or Provider Fraud or Abuse which it had reasonable

cause to suspect, or should have had reasonable cause to suspect, immediately to the Division, and shall cooperate with the Division regarding the investigation. Failure to do so could result in criminal and/or civil penalties. The Contractor must report Member or Provider Fraud or Abuse in a format, to be specified by the Division. The Contractor must use the most current version of the Division's Standard Operating Procedure for MississippiCAN Fraud and Abuse for Referrals and Reporting to PI and MFCU.

Quarterly, the Contractor must report the number of investigations and/or cases of Fraud and Abuse made to the Division that warrant preliminary investigation. The Contractor will immediately notify the Division in the following instances:

1. If the Contractor's preliminary investigation reveals a credible allegation of Fraud; and

2. If the Contractor takes any adverse action against a network Provider for program integrity-related reasons, in accordance with 42 C.F.R. § 1002.3(b)(3).

The Division will notify the Bureau of Program Integrity of any probable Fraud or Abuse that is obtained from, or developed by, the Contractor's system.

T. Subcontractor Disclosures

The Contractor must disclose all information in accordance with 42 C.F.R. § 455.104(b) regarding Subcontractors. The Contractor is responsible for obtaining all disclosure information from all Subcontractors, managing employees, and agent's employees, and submitting to the Division.

The Contractor must disclose all information from their Subcontractors as related to persons convicted of crimes in accordance with 42 C.F.R. § 455.106.

U. Deliverables

The Contractor must obtain Division's prior written approval of all Deliverables prior to the operational date of the Initial Term and throughout the duration of the Contract unless otherwise specified by the Division. Deliverables include, but are not limited to operational policies and procedures, required materials, letters of agreement, Provider Agreements, Provider reimbursement methodology, reports, tracking systems, required files, and quality management program documents. Failure by the Division to respond to approval requests shall not be interpreted as approval of Deliverables.

The Contractor must meet the Division's required time frames for the submission of Deliverables in the event that requested Deliverables do not have a submission time frame specified. In such cases, the Division will specify the time frame for submission of Deliverables.

The Division may impose penalties under Section 15, Default and Termination, of this Contract if the Contractor fails to submit Deliverables for approval based on the requirements set forth in this Contract.

V. Small and Minority Business Reporting

The Division encourages the employment of small business and minority business enterprises. Therefore, the Contractor shall report, separately, the involvement in this contract of small businesses and businesses owned by minorities and women. Such information shall be reported on an invoice annually on the contract anniversary and shall specify the actual dollars contracted to-date with such businesses, actual dollars expended to date with such businesses, and the total dollars planned to be contracted for with such businesses on this contract.

SECTION 11 – FRAUD AND ABUSE

A. General Requirements

The Contractor shall have internal controls, policies and procedures, and a compliance plan to guard against Fraud and Abuse. Specifically, the Contractor shall have written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State standards subject to approval by the Division. The Contractor shall annually review and submit an updated Fraud and Abuse compliance plan to the Division for approval.

B. Fraud and Abuse Compliance Plan

At a minimum, the Fraud and Abuse compliance plan shall comply with the Division's policies and procedures for Fraud and Abuse and include the following:

1. The designation of a Fraud and Abuse Compliance Officer and a compliance committee that is accountable to senior management;

2. Effective training and education for the Fraud and Abuse Compliance Officer and the Contractor's employees;

3. Operation of a Fraud and Abuse Hotline during which all calls are recorded. The Division may request to review call recordings at its discretion;

4. Effective lines of communication between the Fraud and Abuse Compliance Officer and the Contractor's employees;

5. Enforcement of standards through well publicized disciplinary guidelines (e.g., provision for internal monitoring and auditing);

6. Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this Contract;

7. Procedures for:

    a. Conducting regular reviews and audits of operations to guard against Fraud and Abuse;

b. Verifying whether services reimbursed were actually furnished to Members, as required in 42 C.F.R. § 455.1 and 42 C.F.R. § 455.20;

c. Assigning and strengthening internal controls to ensure claims are submitted and payments are made properly;

d. Responding to cases of potential Provider and Member Abuse referred by the Division;

e. Reporting information to the Division; and

f. Developing procedures to monitor service patterns of Providers, Subcontractors, and Members;

8. Assistance to the Division in any investigation or prosecution of Fraud by providing the following:

a. Access to and free copies of computerized data stored by the Contractor;

b. Direct computer access to computerized data stored by the Contractor that is supplied without charge and in the form requested by the Division; and

c. Access to any information possessed or maintained by any Provider of service(s) under the Medicaid State Plan to which the Division and the Contractor are authorized to access.

If the Contractor identifies that a Member or Provider is committing Fraud and Abuse, the Contractor may disenroll the Provider and request to the Division that the Member be disenrolled. However, the Contractor shall not indicate to the Provider or Member that they will be disenrolled from Medicaid.

The Division, designated parties and the Contractor shall meet quarterly to collaborate on Complaints of Fraud and Abuse.

SECTION 12 – FINANCIAL REQUIREMENTS

A. **Capitation Payments**

1. Monthly Payments

On or before the tenth (10th) day of each month during the term of this Contract, the Division shall remit to the Contractor the capitation fee 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. All payments shall be made by electronic funds transfers, the cost of which shall be borne by the Contractor. 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.

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. 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. 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.

2. Payment in Full

The Contractor shall accept the capitation rate 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. At time of capitation rate acceptance, the Contractor shall provide an actuarial certification that states the capitation rates are adequate in light of the Contractor's specific circumstances. Members shall be entitled to receive all covered services for the entire period for which payment has been made by the Division. Any and all costs incurred by the Contractor in excess of the Capitation Payment will 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.

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, 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. The Contractor agrees to refund any overpayment to the Division, and the Division agrees to pay any underpayment to the Contractor, within thirty (30) calendar days following written notice by the Division. In addition, the Division will review rates annually and adjust rates as deemed necessary subject to approval from the Federal government.

4. Application of 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.

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 the Provider the amounts paid for any provided covered services.

6. Reserve Account

   The Contractor shall establish and maintain an insured bank account or a secured investment which is in compliance with the Department of Insurance regulations referenced in Miss. Code Ann. § 83-41-325 (1972, as amended).

7. Reinsurance

   The Contractor must supply a guarantee of coverage letter, with annual updates, for any outstanding claims.

   The Contractor may 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 withholding of payment by the Division, or imposition of penalties by the Division. These arrangements must be approved by the Division.

8. Third Party Resources

   If a Member has resources available for payment of expenses associated with the provision of covered services, other than those which are exempt under Title XIX of the Act, such resources are primary to the coverage provided by the Division and must be exhausted prior to payment by the Division. The Division's billing manual allows the Contractor to bill for EPSDT, Title IV-D, and pregnancy-related services prior to Third Party Resources.

   The capitation rates set forth in this Contract have been adjusted to account for the primary liability of third parties to pay such expenses. The Contractor shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to Members pursuant to this Contract. All funds recovered by the Contractor from Third Party Resources shall be treated as income to the Contractor. The Contractor shall coordinate with the Division on all aspects of Third Party Resources.

The Contractor may delay payment of a Subcontractor or Non-Contracted Provider for up to sixty (60) calendar days following the date of receipt of the claims by the Contractor in the event that a Third Party Resource is identified from which the Subcontractor or Non-Contracted Provider is obligated to collect payment. If payment is made by the third party directly to a Subcontractor or Non-Contracted Provider within sixty (60) calendar days following the date of service, the Contractor may pay the Subcontractor or Non-Contracted Provider only the amount, if any, by which the allowable claim exceeds the amount of the Third Party Liability. If payment is not made by the third party within such sixty (60) calendar day period, the Contractor must pay the Subcontractor or Non-Contracted Provider and obtain a refund of any subsequent payments made by the third party. The Contractor may not withhold payment from a Subcontractor or Non-Contracted Provider for services provided to a Member due to the existence of Third Party Resources, because the liability of a Third Party Resource cannot be determined, or because payment will not be available within sixty (60) calendar days.

The exception to the sixty (60) calendar day delayed payment rule is for prescribed drugs which are paid pursuant to an approved waiver described in 42 C.F.R. § 433.139(b)(2)(i) and for medical services provided to pregnant women and children as specified in 42 C.F.R. § 433.139 (b)(2)(ii) and (3). These services must be paid to the Subcontractor or Non-Contracted Provider and the Contractor must pursue recovery from the liable Third Party Resource.

9. Capitation Rates

Exhibit A, Capitation Rates, of this Contract includes the capitation rates per member per month (PMPM) varying by region and rate cell. Each Contractor will be paid based on the distribution of Members they have in each rate cell. In addition, Contractor Capitation Payments will vary based on their Members' county of residence**.** The SSI/Disabled and MA Adult rate cells will be risk adjusted and rates re-calculated based on each CCO's actual risk scores.

B. **Maternity Kick Payment**

A Maternity Kick Payment is a case rate payment to the Contractor for hospital inpatient physician maternity services for a delivery, as defined by the Division. The Division will pay the Maternity Kick Payment to the Contractor on a monthly basis when a Member delivers a live baby or stillborn baby. The Contractor will be paid one Maternity Kick Payment per delivery, with the exception of delayed deliveries. The Maternity Kick Payment is paid to the Contractor in addition to the monthly full risk, prepaid capitation rate.

C. **Indemnification and Insurance**

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

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

2. To indemnify and hold harmless the State, its officers, Agents, and employees, and the Members and their eligible dependents from liability deriving or resulting from the Contractor's Insolvency or inability or failure to pay or reimburse participating Providers or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this contract.

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

4. Any and all liability, loss, damages, costs or expenses which the Division or the State may incur, sustain or be required to pay by reason of the Contractor, its employees, agents or assigns: 1) failing to honor copyright, patent or licensing rights to software, programs or technology of any kind in providing services to the Division, or 2) breaching in any manner the confidentiality required pursuant to federal and State law(s) and regulations.

5. Any and all liability, loss, damage, costs or expenses which the Division may sustain, incur or be required to pay: 1) by reason of any person suffering personal injury, death or property loss or damage of any kind either while participating with or receiving services from the Contractor under this contract, or while on premises owned, leased, or operated by the Contractor or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for or in the control of the Contractor or any officer, agent, or employee thereof; or 2) by reason of the Contractor or its employee, agent, or person within its scope of authority of this contract causing injury to, or damage to the person or property of a person including but not limited to the Division or the Contractor, their employees or agents, during any time when the Contractor or any officer, agent, employee thereof has undertaken or is furnishing the services called for under this Contract.

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

7. All claims and losses accruing or resulting to any and all the Contractor employees, agents, Subcontractors, laborers, and any other person, association, partnership,

entity, or corporation furnishing or supplying work, services, materials, or supplies in connection with performance of this contract, and from any and all claims and losses accruing or resulting to any such person, association, partnership, entity, or corporation who may be injured, damaged, or suffer any loss by the Contractor in the performance of the Contract.

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

If in the reasonable judgment of the Division a default by the Contractor is not so substantial as to require termination and reasonable efforts to induce the Contractor to cure the default are unsuccessful and the default is capable of being cured by the Division or by another resource without unduly interfering with the continued performance of the Contractor, the Division may provide or procure such services as are reasonably necessary to correct the default. In such event, the Contractor shall reimburse the Division for the cost of those services in accordance with Section 15.F, Retainage, of this Contract.

D. **Limitation of Liability**

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

E. **Federal, State, and Local Taxes**

Unless otherwise provided herein, the contract price shall include all applicable federal, state, and local taxes.

The Contractor shall pay all 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 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 the Contractor may be liable as a result of this Contract.

F. **Medical Loss Ratio**

The Contractor shall provide an annual Medical Loss Ratio (MLR) report by January 1 following the end of the MLR Reporting Year, which shall be the State's fiscal year. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the Contractor shall refund the Division the

difference by February 1 following the end of the Reporting Year. Any unpaid balances after February 1 shall be subject to interest of ten percent (10%) per annum.

See Exhibit C, Medical Loss Ratio (MLR) Calculation Methodology, of this Contract for MLR calculation methodology and classification of costs.

G. **Health Insurer Fee Under Section 9010 of the Patient Protection and Affordability Act of 2010**

The Division will annually reimburse Contractor the full cost of the Health Insurer Fee that Contractor incurs and becomes obligated to pay pursuant to Section 9010 of the Patient Protection and Affordability Act of 2010 due to its receipt of Medicaid premiums pursuant to the Contract. The full cost of the Health Insurer Fee will include both the health insurer fee and the allowance to reflect the federal income tax liability related to the health insurer fee occurred. DOM and the Contractor agree to amend the above language once the finalized methodology is developed by DOM and approved by CMS.

SECTION 13 – THIRD PARTY LIABILITY

The Contractor will have the option of pursuing payments from liable third parties. If the Contractor selects to Subcontract with any individual, firm, corporation, or any other entity, the Contractor shall notify the Division not less than thirty (30) calendar days in advance of its desire to Subcontract and include a copy of the proposed Subcontract with notification of and information about the proposed Subcontractor. The Subcontract must receive written approval from the Division prior to the effective date of the Subcontract.

When handling a subrogation case, all initial letters sent to third parties (i.e., attorneys or insurance companies) should place the third party on notice that the Division may have a separate lien for services not covered by the Contractor (e.g., inpatient hospital services) and provide contact information for Division's designated third party staff member. Under no circumstances may the Contractor or any Subcontractor imply that they are an Agent of the State or Division. The Division will provide language that must be included in all of the form letters issued by the Contractor and/or any Subcontractors.

The Contractor shall obtain written approval from the Division for all form letter templates and form document templates prior to use. The Contractor shall submit a copy of all form letter templates and form document templates to the Division for written approval and as part of the readiness review process. The Division will impose liquidated damages in accordance with Section 15, Default and Termination, of this Contract in the event of non-compliance.

In the event the Division has a claim related to the accident, the Contractor will not be able to negotiate its claim without first notifying the Division. The Division subrogation claim takes priority over the Contractor's subrogation claim. In cases where the Division and Contractor both have claims related to the accident and the settlement or verdict amount is insufficient to satisfy both claims, at the sole discretion of the Division, the Division and Contractor may divide the proceeds .

Periodic meetings may be required with the Contractor's compliance personnel and the Division.

The Contractor shall prepare a standard subrogation release of claim that relates only to the claims the Contractor may have. The Contractor shall not execute releases sent in by third parties.

The Contractor will be prohibited from stating or implying that it is Division of Medicaid; however, it is appropriate to state that the Contractor provides services for Division of Medicaid.

The Contractor must educate insurers and attorneys who are representing the Contractor about Mississippi Medicaid and the MississippiCAN Program, the differences between the two (2) programs and how representation for issues related to the Contractor's role in management of the MississippiCAN Program do not imply representation for the full Medicaid program. Education must clarify that at no point may an insurer or attorneys imply that they are representing Medicaid, acting as an Agent of the State, or imply they are settling on behalf of the State or the Division of Medicaid.

For guidance with respect to Third Party Resources, please refer to Section 12.A, Capitation Payments, of this Contract.

SECTION 14 – SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION

A. **Right to Enter Into Other Contracts**

The Division and the Contractor agree that each may contract for the provision or purchase of services for and from third parties not related to this contract arrangement, subject to Division approval.

The Division may undertake or award other contracts for services related to the services described in this contract or any portion herein. Such other contracts include, but are not limited to consultants retained by the Division to perform functions related in whole or in part to Contractor services. The Contractor shall fully cooperate with such other Contractors and the Division in all such cases.

B. **Requirements**

The Contractor has the right to Subcontract to provide services specified under this contract. Any Subcontract into which the Contractor enters with respect to performance under the contract shall in no way relieve the Contractor of the legal responsibility to carry out the terms of this contract. The Division will consider the Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the contract. Nothing contained in the Subcontract shall be construed as creating any contractual responsibility between the Subcontractor(s) and the Division. The Contractor is solely responsible for fulfillment of the Contract terms with the Division and for the performance of any Subcontractor under such Subcontract approved by the Division. The Division will make Contract payments only to the

Contractor.

The Contractor shall not Subcontract any portion of the services to be performed under this Contract without the prior written approval of the Division. All Subcontracts may be subject to review and approval by the Division and must include all Division required terms and conditions. At contract award, the Division will provide a checklist of specific requirements that the Contractor must include in every Subcontract supporting the MississippiCAN Program. When submitting the Subcontract to the Division for approval, the Contractor must provide the completed checklist to indicate where within the Subcontract the requirement is addressed.

A Subcontract that must be submitted to the Division for advance written approval is any Subcontract between the Contractor and any individual, firm, corporation or any other entity to perform part or all of the selected Contractor's responsibilities under this Contract. This provision includes, but is not limited to, contracts for Behavioral Health Services, vision services, dental services, claims processing, pharmacy services, third party services and Member services. This provision does not include, for example, purchase orders. The contract language for Subcontractors must be standardized, as approved by the Division. The Contractor must submit the Subcontract to the Division for advance written approval not less than thirty (30) calendar days in advance of its desire to Subcontract.

The Contractor must oversee and will be held accountable for any functions and responsibilities that it delegates to any Subcontractor or subsidiary. All Subcontracts and agreements must be in writing, must specify the activities and report responsibilities delegated to the Subcontractor and provide for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate, and shall contain provisions such that it is consistent with the Contractor's obligations pursuant to this Contract.

Approval of any Subcontract shall neither obligate the Division nor the State of Mississippi as a party to that Subcontract nor create any right, claim, or interest for the Subcontractor against the State of Mississippi or the Division, their agents, their employees, their representatives, or successors.

The Contractor must monitor each Subcontractor's performance on an ongoing basis, subject it to formal review at least once a year, and include the results of this review in Annual Quality Management Program Evaluation. If the Contractor identifies deficiencies or areas for improvement in the performance of any of its Subcontractors that is providing services under this Contract, the Contractor must take corrective action. The Subcontract must comply with the provisions of this Contract, and must include any general requirements of this Contract that are appropriate to the service or activity identified. It is not required that Subcontractors be enrolled as a Medicaid Provider. However, they are encouraged to enroll if they provide services not covered under this Contract on a Fee-for-Service basis.

Subcontracts and revisions to Subcontracts must be maintained and available for review at one (1) central office in Mississippi designated by the Contractor and approved by the

Division.

The Division may refuse to enter into or renew an agreement with a Contractor if any Subcontractor entity has any person who has an ownership or control interest in the Subcontract entity, or who is an agent or managing employee of the Subcontractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program.

The Division may refuse to enter into or may terminate this agreement if it determines that the Contractor did not fully and accurately make any disclosure of any Subcontractor entity required under 42 C.F.R. § 455.106.

Disclosure by Providers and State Medicaid agencies must be in accordance with 42 C.F.R. § 1002.3.

Before the Division enters into or renews a contract agreement, or at any time upon written request by the Division, the Contractor must disclose to the Division the identity of any person described in 42 C.F.R. § 1001.1001(a)(1) and 1002.3 related to any Subcontractor entities.

The Division may refuse to enter into or renew this contract if any person who has ownership or control interest in any Subcontractor entity, or who is an agent or managing employee of the Subcontractor entity, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XIX Services Program.

The Division may refuse to enter into, or terminate, this contract if it determines that the Subcontractor entity did not fully and accurately make any disclosure required under 42 C.F.R. § 1002.3(a).

The Contractor shall give the Division immediate written notice by certified mail, facsimile, or any other carrier that requires signature upon receipt of any action or suit filed and prompt notice of any claim made against the Contractor or Subcontractor which in the opinion of the Contractor may result in litigation related in any way to the Contract with the Division.

C. **Remedies**

The Division shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract. Suspected Fraud and Abuse by any Subcontractor will be investigated by the Division.

SECTION 15 – DEFAULT AND TERMINATION

A. **Sanctions**

In the event the Division finds the Contractor to be non-compliant with program standards, performance standards, provisions of this Contract, or the applicable statutes or rules governing Medicaid prepaid health plans, the Division shall issue a written notice of deficiency, request a corrective action plan and/or specify the manner and time frame in which the deficiency is to be cured. If the Contractor fails to cure the deficiency as ordered, the Division shall have the right to exercise any of the administrative sanction options described below, in addition to any other rights and remedies that may be available to the Division. The type of action taken shall be in relation to the nature and severity of the deficiency.

The Division shall provide the Contractor fifteen (15) calendar days written notice before sanctions as specified above are imposed which will include the basis and nature of the sanction.

B. **Disputes of Sanctions or Damages**

In order to Appeal the Division imposition of any sanctions or damages, the Contractor shall request review by and submit supporting documentation first to the Deputy Administrator of Health Services within thirty (30) calendar days of receipt of notice.

The Deputy shall issue a decision within thirty (30) calendar days after receipt of the final written submission by either the Contractor or the Division.

Thereafter, the Contractor may obtain a second review by the Executive Director by filing the request for review with supporting documentation and copy of the Deputy's decision within thirty (30) calendar days of the Contractor's receipt of the decision.

The imposition of sanctions and liquidated damages is not automatically stayed pending Appeal. Pending final determination of any dispute hereunder, the Contractor shall proceed diligently with the performance of this contract and in accordance with the Contracting Officer's direction.

C. **Inspection and Monitoring**

Pursuant to the requirements of 42 C.F.R § 438.6, the Division, the Mississippi Department of Audit, the Department of Health and Human Services (DHHS), the Centers for Medicare and Medicaid Services (CMS),CMS, the Office of Inspector General (OIG), the General Accounting Office (GAO), and any other auditing agency prior-approved by the Division, or authorized representatives of these parties including, without limitation, any employee, agent, or Contractor of the Division, CMS, the Division's Agent, the Division's Program Integrity Bureau and the State Medicaid Fraud Control Unit, shall, at reasonable times, have the right to enter onto the Contractor's premises, or such other places where duties under this Contract are being performed, with or without notice, to inspect, monitor, or otherwise evaluate (including periodic

systems testing) the work being performed by the Contractor, Subcontractor or supplier. All inspections and evaluations shall be performed in such a manner as will not unduly delay work. Refusal by the Contractor to allow access to all documents, papers, letters or other materials, shall constitute a breach of contract. All audits performed by persons other than Division staff will be coordinated through the Division and its staff.

Such monitoring activities shall include, but are not limited to, on-site inspections of all service locations and health care facilities; auditing and/or review of all records developed under this contract including periodic medical audits, Grievances, Enrollments, Disenrollments, termination, utilization and financial records, reviewing management systems and procedures developed under this contract and review of any other areas of materials relevant to or pertaining to this contract. Because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes, emphasis will be placed on case record validation during periodic monitoring visits to project sites. The Division shall prepare a report of its findings and recommendations and require the Contractor to develop corrective action plan to address any deficiencies.

D. **Corrective Action**

The Division may require corrective action in the event that any report, filing, examination, audit, survey, inspection, investigation or the like should indicate that the Contractor, any Subcontractor or supplier is not in compliance with any provision of this Contract, or in the event that the Division receives a Complaint concerning the standard of care rendered by the Contractor, any Subcontractor or supplier. The Division may also require the modification of any policies or procedures of the Contractor relating to the fulfillment of its obligations pursuant to this Contract. The Division may issue a deficiency notice and may require a corrective action plan be filed within fifteen (15) calendar days following the date of the notice. A corrective action plan shall delineate the time and manner in which each deficiency is to be corrected. The corrective action plan shall be subject to approval by the Division, which may accept it as submitted, accept it with specified modifications or reject it. The Division may extend or reduce the time frame for corrective action depending upon the nature of the deficiency, and shall be entitled to exercise any other right or remedy available to it, whether or not it issues a deficiency notice or provides the Contractor with the opportunity to take corrective action. In appropriate instances, the Division may refer the matter to the State Medicaid Fraud Control Unit for investigation and possible criminal prosecution.

E. **Liquidated Damages**

1. Failure to Meet Contract Requirements

The Division reserves the right to assess actual or liquidated damages, upon the Contractor's failure to provide timely services required pursuant to this contract. It is agreed by the Division and the Contractor that in the event of the Contractor's failure to meet the requirements provided in this Contract and/or all documents incorporated herein, damage will be sustained by the Division and the actual damages which will

be sustained by event of and by reason of such failure are uncertain, and extremely difficult and impractical to ascertain and determine. The parties therefore agree that the Contractor will pay the Division liquidated damages in the fixed amounts as stated in Table 9; provided however, that if it is finally determined that the Contractor would have been able to meet the Contract requirements listed below but for the Division's failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly therefrom. The Division may impose liquidated damages upon the Contractor when it fails to timely and accurately submit any reports under this Contract.

The purpose of establishing and imposing monetary penalties is to provide a means for the Division to obtain the services and level of performance required for successful operation of the Contract. The Division's failure to assess monetary penalties in one or more of the particular instances described herein will in no event waive the right for the Division to assess additional monetary penalties or actual damages. Continued violations of the Deliverable requirements set forth in Table 9 may result in termination of the Contract by the Division.

The assessment of any actual or liquidated damages will be offset against the subsequent monthly payments to the Contractor. Assessment of any actual or liquidated damages does not waive any other remedies available to the Division pursuant to this Contract or State or Federal law. If liquidated damages are known to be insufficient then the Division has the right to pursue actual damages.

Table 9. Monetary Penalties

Failed Deliverable	Damages
Call Center Performance	If the Contractor's average abandonment rate for any period exceeds five percent (5%) for the Member Services and/or Provider Services Call Centers, the Contractor will be penalized up to ten thousand dollars ($10,000.00) per monthly period.
Claims Payment	If the Contractor fails to meet the targets outlined in Section 7.J.1, Claims Payment, of this Contract, the Division shall deem this to be an instance of unsatisfactory claims performance and the Contractor will pay a fine of fifteen thousand dollars ($15,000.00) for each month that such determination is made. Should the Contractor have two (2) consecutive months of unsatisfactory claims performance, the Division shall immediately suspend Enrollment of MississippiCAN Members with the Contractor, until such time as the Contractor successfully demonstrates that all past due clean claims have been paid or denied.
Corrective Action	Failure to complete corrective action as described in Section 15.D, Corrective Action, of this Contract, the Contractor shall pay liquidated damages in the amount of three thousand dollars ($3,000.00) per calendar day for each day the corrective action is not completed in accordance with the timeline established in the corrective action plan.
Encounter Data	The Contractor will be responsible for processing claims within ninety (90) calendar days of receipt unless pended for additional information or to determine medical necessity. The Contractor shall submit complete encounter data to the Division that meets Federal requirements and allows the Division to monitor the program. The Division will establish minimum standards for financial and administrative accuracy and for timeliness of processing; these standards will be no less than the standards currently in place for the Medicaid fee- for-service program. If the Contractor does not meet these standards, the Contractor may be penalized each month encounter data is not submitted or not submitted in compliance with the Division's requirements for timeliness, completeness and accuracy. The Contractor will be penalized up to the following amounts: a. Ten thousand dollars ($10,000.00) per calendar day for each day encounter data is received after the due date, b. Ten thousand dollars ($10,000.00) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in the Contract, and c. Ten thousand dollars ($10,000.00) per calendar day for each day the Contractor fails to correct and resubmit encounter data that was originally returned to the Contractor for correction because the error rate for the submission data was in excess of the five percent (5%), until acceptance.

<table>
<tr><th>Failed Deliverable</th><th>Damages</th></tr>
<tr><td>EPSDT Screening and Immunization</td><td>During year one (1) of this Contract, achievement of less than eighty-five percent (85%) screening and less than ninety percent (90%) immunization rate (the lowest rate shall be considered to be the rate for both screenings and immunizations) will require a refund of one hundred ($100) per Member for all Members nineteen (19) years of age and younger. The Division will re-evaluate this level in subsequent years of the Contract and notify the Contractor in writing of changes.</td></tr>
<tr><td>General Deliverables and Reports</td><td>For each day that a Deliverable or required report is late, incorrect or deficient, the Contractor may be liable to the Division for monetary penalties in an amount per calendar day per Deliverable as specified in the table below for reports and Deliverables not otherwise specified in this table. Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Contract.
<table>
<tr><th>Occurrence</th><th>Daily Amount for Days 1-14</th><th>Daily Amount for Days 15-30</th><th>Daily Amount for Days 31-60</th><th>Daily Amount for Days 61 and Beyond</th></tr>
<tr><td>1-3</td><td>$750</td><td>$1,200</td><td>$2,000</td><td>$3,000</td></tr>
<tr><td>4-6</td><td>$1,000</td><td>$1,500</td><td>$3,000</td><td>$5,000</td></tr>
<tr><td>7-9</td><td>$1,500</td><td>$2,000</td><td>$4,000</td><td>$6,000</td></tr>
<tr><td>10-12</td><td>$2,000</td><td>$3,000</td><td>$5,000</td><td>$8,000</td></tr>
<tr><td>13 and Beyond</td><td>$4,000</td><td>$7,000</td><td>$9,500</td><td>$12,000</td></tr>
</table></td></tr>
<tr><td>Marketing</td><td>If the Division determines that the Contractor has violated the requirements of the Contractor’s obligations with respect to Marketing and marketing materials, the Contractor will pay a fine in the amount of twenty-five thousand dollars ($25,000.00) for each violation, in connection with an audit or investigation.</td></tr>
<tr><td>Medicaid Investigated Grievances</td><td>If the Contractor is subject to more than three (3) valid Medicaid Investigated Grievances in any one (1) month, The Division may assess civil monetary penalties of up to ten thousand dollars ($10,000.00) for each such valid Medicaid Investigated Grievance above three (3) per month.</td></tr>
</table>

Failed Deliverable	Damages
Network Access Report and Provider Network Reports	If the Division determines that the Contractor has not met the established Provider Network access standards, the Division shall impose sanctions on the Contractor and require submission of a Correction Action Plan to the Division within fifteen (15) business days following imposition of sanctions. Determination of failure to meet network access standards shall be made following a review of the Contractor's Network Geographic Access Assessment (GeoAccess) Report. Contractor will pay a fine in the amount of fifteen thousand dollars ($15,000.00) for each month that the Contractor fails to meet the Provider Network access standards. Further, should the Contractor fail to meet the Provider Network access standards for two (2) consecutive reporting quarters, the Division shall immediately suspend Enrollment of MississippiCAN Members with the Contractor until the Contractor successfully demonstrates compliance with the Provider Network access standards. Continued failure to meet Provider Network access standards may result in termination of the contract by the Division.
Non-Emergency Transportation	The Contractor shall authorize and schedule routine NET services for ninety-eight percent (98%) of all requests within three (3) business days after receipt of the request. Contractor shall authorize and schedule routine NET services for one hundred percent (100%) of all requests within ten (10) business days after receipt of a request. If the Contractor fails to achieve these targets, the Contractor will be penalized up to ten thousand dollars ($10,000.00) per monthly period.
Provider Credentialing	If the Division determines that the Contractor has not completed credentialing of Providers within ninety (90) calendar days, the Division may impose penalties of up to five thousand dollars ($5,000.00) per violation.
Third Party Liability Form Letters and Form Documents	If the Contractor fails to submit form letter templates and form document templates to the Division for advance written approval or fails to use the approved letter templates and form document templates, the Division may impose penalties of up to five thousand dollars ($5,000.00) per violation.
Subcontractor Prior Approval	The Contractor's failure to obtain advance written approval of a Subcontract will result in the application of a penalty of one (1) month's Capitation Payment rates for each day that the Subcontractor was in effect without the Division's approval.

With the exception of encounter data submissions, the Division will utilize the following guidelines to determine whether a report is correct and complete for the purposes of liquidated damages: (a) The report must contain one hundred percent (100%) of the Contractor's data; (b) ninety-nine percent (99%) of the required items for the report must be completed; and (c) ninety-nine point five percent (99.5%) of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by the Division.

Liquidated damages for late reports or Deliverables shall begin on the first day the report is late. Liquidated damages for incorrect reports or deficient Deliverables shall begin on the sixteenth (16th) calendar day after the date on the written notice provided by the Division to the Contractor that the report remains incorrect or the Deliverables remain deficient.

Any liquidated damages assessed by the Division shall be due and payable to the Division within thirty (30) calendar days after the Contractor's receipt of their notice of assessment. If payment is not made by the due date, said liquidated damages shall be withheld from future Capitation Payments by the Division without further notice. The collection of liquidated damages by the Division shall be made without regard to any Appeal rights the Contractor may have pursuant to this Contract. However, in the event an Appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by the Division will be returned to the Contractor.

Whenever liquidated damages for a single occurrence exceed two thousand five hundred dollars ($2,500.00), Contractor staff will meet with Division staff to discuss the causes of the occurrence and to negotiate a reasonable plan for corrective action. Once a corrective action plan is agreed upon by both parties, collection of liquidated damages during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for correction of the problems that led to the occurrence. Should that date be missed by the Contractor, the original schedule of damages will be reinstated, including collection of damages for the corrective action period, and liquidated damages will continue until satisfactory correction of the occurrence, as determined by the Division, has been made.

If the Contractor fails to fulfill its duties and obligations pursuant to this contract, the Division may issue a written notice to the Contractor indicating the violation(s) and advising the Contractor that failure to cure the violation(s) within a defined time span, to the satisfaction of the Division, may lead to the imposition of all or some of the sanctions listed below:

a. Suspension of further Enrollment after notification by the Division of a determination of a contract violation. Whenever the Division determines that the Contractor is out of compliance with this contract, the Division may suspend Enrollment of new Members into the Contractor. The Division, when exercising this option, must notify the Contractor in writing of its intent to suspend new Enrollment at least seven (7) business days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Division, or may be indefinite. The Division may also notify existing Members of the Contractor non-compliance and provide an opportunity to disenroll from the Contractor and/or to re-enroll with another Contractor;

b. Suspension or recoupment of the capitation rate paid for:

    i. Any month for any Member denied the full extent of covered services

meeting the standards set by this Contract or who received or is receiving substandard services after notification by the Division of a determination of a contract violation. Whenever the Division determines that the Contractor has failed to provide to a Member any medically necessary items and/or covered services required under this contract, the Division may impose a fine of up to twenty five thousand dollars ($25,000). The Contractor shall be given at least fifteen (15) calendar days written notice prior to the withholding of any Capitation Payment;

ii. Months in which reports are not submitted as required in this Contract after notification by the Division of a determination of a Contract violation. Whenever the Division determines that the Contractor has failed to submit any data or report required pursuant to this Contract accurately, in satisfactory form, and within the specified time frame, the Division shall have the right to withhold one percent (1%) of the next monthly capitation payment and thereafter until the data or report is received by the Division;

c. Notwithstanding the provisions contained in this contract, the Division may withhold portions of Capitation Payments from the Contractor as provided herein;

d. Civil money penalties of no more than one hundred thousand dollars ($100,000) for acts of discrimination against individuals or Providers or misrepresentation of information to CMS or the Division;

e. Temporary management upon a finding by the Division that there is continued egregious behavior or substantial risk to the health of Members in accordance with § 1932(e)(2) of the Social Security Act Termination of this contract;

f. Reduce or eliminate Marketing and/or community event participation;

g. Refuse to allow participation in Contractor pay for performance programs;

h. Refuse to renew the contract;

i. In the case of inappropriate Marketing activities, referral may also be made to the Department of Insurance for review and appropriate enforcement action;

j. Require special training or retraining of Marketing representatives including, but not limited to, business ethics, Marketing policies, effective sales practices, and State Marketing policies and regulations, at the Contractor's expense;

k. In the event the Contractor becomes financially impaired to the point of threatening the ability of the State to obtain the services provided for under the contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately

terminate this contract effective the close of business on the date specified;

l. Refuse to consider for future contracting a Contractor that fails to submit encounter data on a timely and accurate basis;

m. Refer any matter to the applicable Federal agencies for civil money penalties;

n. Refer any matter to the Mississippi Division of Civil Rights where applicable;

o. Exclude the Contractor from participation in the Medicaid program; and

p. Refer any matter to the Mississippi Division of Consumer Affairs.

2. Termination of the Contract

The Contractor acknowledges and agrees that the Division has incurred substantial expense in connection with the preparation and entry into this contract, including expenses related to training of staff, data collection and processing, actuarial determination of capitation rates for the initial term and each renewal term, and ongoing changes to the Medicaid Management Information System (MMIS)/ Medicaid Enterprise System (MES) operated by the Division. The Contractor further acknowledges and agrees that in the event this contract is terminated prior to the end of the initial term or any renewal term, due to the actions of the Contractor or due to the Contractor's failure to fully comply with the terms and conditions of this contract, the Division will incur substantial additional expense in processing the Disenrollment of all Members and mass MMIS changes, in effecting additional staffing changes, in procuring alternate health care arrangements for Members and in modifying any Member service materials identifying the Contractor; and that such expense is difficult or impossible to accurately estimate.

Based upon the foregoing, the Contractor and the Division have agreed to provide for the payment by the Contractor to the Division of liquidated damages equal to ten thousand dollars ($10,000.00) plus, for each month of the contract term remaining after the effective date of termination, five percent (5%) of the maximum monthly Capitation Payment, such payment to be made no later than thirty (30) calendar days following the date of the notice of termination. The Division and the Contractor agree that the sum set forth herein as liquidated damages is a reasonable estimate of the probable loss which will be incurred by the Division in the event this contract is terminated prior to the end of the Contract term or any renewal term due to the actions of the Contractor or due to the Contractor's failure to comply fully with the terms and conditions of this contract. In addition, the Contractor will reimburse the Division for any Federal disallowances or sanctions imposed on the Division as a result of the Contractor's failure to abide by the terms of this contract.

The Division and the Contractor agree that this Paragraph E.2., Section 15, relating to liquidated damages does not apply if the Contract is terminated without cause in accordance with Paragraph I, Section 15.

F. **Retainage**

If the Contractor's failure to perform satisfactorily exposes the Division to the likelihood of contracting with another person or entity to perform services required of the Contractor under this contract, upon notice setting forth the services and retainage, the Division may withhold from the Contractor payments in an amount commensurate with the costs anticipated to be incurred. If costs are incurred, the Division shall account to the Contractor and return any excess to the Contractor. If the retainage is not sufficient, the Contractor shall immediately reimburse the Division the difference or the Division may offset from any payments due the Contractor. The Contractor will cooperate fully with the retained Contractor and provide any assistance it needs to implement the terms of its agreement for services for retainage.

The Contractor shall cooperate with the Division or those procured resources in allowing access to facilities, equipment, data or any other Contractor resources to which access is required to correct the failure. The Contractor shall remain liable for ensuring that all operational performance standards remain satisfied.

G. **Stop Work Order**

1. **Order to Stop Work:** The Division Contract Administrator may, by written order to the Contractor at any time and without notice to any surety, require the Contractor to stop all or any part of the work called for by this contract. This order shall be for a specified period not exceeding ninety (90) calendar days after the order is delivered to the Contractor, unless the parties agree to an extension. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, the Contractor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allowable to the work covered by the order during the period of work stoppage. Before the stop work order expires, or within an extension to which the parties shall have agreed, the Contract Administrator shall either:

    a. Cancel the stop work order; or

    b. Terminate the work covered by such order as provided in the "Termination for Default Clause" or the "Termination for Convenience Clause" of this contract.

2. **Cancellation or Expiration of the Order:** If a stop work order issued under this clause is canceled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the Contractor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or Contractor price, or both, and the contract shall be modified in writing accordingly, only if:

    a. The stop work order or extension results in an increase in the time required for, or in the Contractor's cost properly allocable to, the performance of any part of this contract; and

b. The Contractor asserts a claim for such an adjustment within thirty (30) calendar days after the end of the stop work order or extension.

3. **Termination of Work:** If a stop work order or extension is not canceled and the work covered by such stop work order or extension is terminated for default or convenience, adjustment to the contract price will be negotiated between the Division and the Contractor.

H. **Action by the Mississippi Department of Insurance**

Upon receipt of official notice that the Mississippi Department of Insurance has taken action which resulted in the Contractor being placed under administrative supervision, the Division will suspend further Enrollment of Medicaid beneficiaries until notice is received from the Department of Insurance that administration supervision is no longer needed.

Upon receipt of official notice that the Mississippi Department of Insurance has taken action, which resulted in the Contractor being placed in rehabilitation, the Division will immediately disenroll all Members who are Medicaid beneficiaries and suspend further Enrollment of Medicaid beneficiaries until notice is received from the Department of Insurance that the Contractor has been rehabilitated. If the Division disenrolls Medicaid beneficiaries before the end of the month, the Rehabilitator will be notified of the prorated amount of payment due to the Division for the days of the month not covered by the Contractor for each Medicaid Member and the Division shall be entitled to reimbursement for said amounts. Violation of this section may result in termination of the contract by the Division.

I. **Option to Terminate**

This contract may be terminated without cause by either party upon ninety (90) calendar days prior written notice to the other party. Termination shall be effective only at midnight of the last day of a calendar month. The option of the Contractor to terminate this contract prior to the end of the initial term or any renewal term shall be contingent upon performance of all obligations upon termination as defined in this contract, and payment in full of any refunds, outstanding liquidated damages, or other sums due the Division pursuant to this Contract.

J. **Termination by the Division**

1. General Requirements

The Division shall have the right to terminate this Contract upon the occurrence of any of the following events:

a. For default by the Contractor;

b. For convenience;

c. For the Contractor's bankruptcy, Insolvency, receivership, liquidation; and

d. For non-availability of funds.

At the Division's option, termination for reasons (a) through (d) listed herein may also be considered termination for convenience.

The findings by the Executive Director of the Division of the occurrence of any of the events stated above shall be conclusive. The Division will attempt to provide the Contractor with ten (10) calendar days' notice of the possible occurrence of events as described in this contract.

2. Termination for Default by the Contractor

The Division may immediately terminate this contract in whole or in part whenever the Division determines that the Contractor has failed to satisfactorily perform its contractual duties and responsibilities and is unable to resolve such failure within a period of time specified by the Division, after considering the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Division of any such failure to satisfactorily perform its contractual duties and responsibilities, the Division may notify the Contractor of the failure and establish a reasonable time period in which to resolve such failure. If the Contractor does not resolve the failure within the specified time period, The Division will notify the Contractor that the contract in full or in part has been terminated for default. Such notices shall be in writing and delivered to the Contractor by certified mail, return receipt requested, or in person.

If, after Notice of Termination for default, it is determined that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control and without error or negligence on the part of the Contractor or any Subcontractor, the Notice of Termination shall be deemed to have been issued as a termination for the convenience of the Division, and the rights and obligations of the parties shall be governed accordingly.

In the event of Termination for Default, in full or in part as provided by this clause, the Division may procure, upon such terms and in such manner as the Division may deem appropriate, supplies or services similar to those terminated, and the Contractor shall be liable to the Division for any excess costs for such similar supplies or services for the remainder of the contract period. In addition, the Contractor shall be liable to the Division for administrative costs incurred by the Division in procuring such similar supplies or services.

In the event of a termination for default, the Contractor may, at the Division's discretion, be paid for those Deliverables which the Contractor has delivered to the Division. Payments for completed Deliverables delivered to and accepted by the Division shall be at the contract price.

The rights and remedies of the Division provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the contract.

3. Termination for Convenience

   The Division may terminate performance of work under the contract in whole or in part whenever for any reason the Division shall determine that such termination is in the best interest of the Division.

   In the event that the Division elects to terminate the contract pursuant to this provision, it shall notify the Contractor by certified mail, return receipt requested, or delivered in person. Termination shall be effective as of the close of business on the date specified in the notice, which shall be at least thirty (30) calendar days from the date of receipt of the notice by the Contractor.

   Upon receipt of Notice of Termination for convenience, the Contractor shall be paid the following:

   a. The contract price(s) for completed Deliverables delivered to and accepted by the Division; and

   b. A price commensurate with the actual cost of performance for partially completed Deliverables, which also requires acceptance by the Division.

4. Termination for the Contractor Bankruptcy

   In the event that the Contractor shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets, or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to Insolvency or the protection of the rights of creditors, the Division may, at its option, terminate this contract in whole or in part.

   In the event the Division elects to terminate the contract under this provision, it shall do so by sending Notice of Termination to the Contractor by certified mail, return receipt requested, or delivered in person. The date of termination shall be the close of business on the date specified in such notice to the Contractor. In the event of the filing of a petition in bankruptcy by or against a principal Subcontractor, the Contractor shall immediately so advise the Division.

   The Contractor shall ensure and shall satisfactorily demonstrate to the Division that all tasks related to the Subcontract are performed in accordance with the terms of this contract.

5. Availability of Funds

   It is expressly understood and agreed that the obligation of the Division to proceed

under this agreement is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to the State, the State shall have the right upon ten (10) working days written notice to the Contractor, to terminate this agreement without damage, penalty, cost, or expense to the State of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

K. **Procedure on Termination**

1. Notice of Termination

Upon termination of the Contract for any reason except as described in Section 15.H, Action of the Mississippi Department of Insurance, of this Contract, the Division will provide the Contractor with a pre-termination conference. The Division will give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the conference. After the conference, the Division will give the Contractor written notice of the decision. If the decision is to affirm the termination, the notice will provide the effective date of the termination. The Division is required to notify Members of the Division's intent to terminate the Contract and give Members the opportunity to disenroll immediately from the Contractor without cause with the option to enroll in another CCO, as appropriate.

If the Contract is terminated because the Contractor is not in compliance with terms of this Contract and if directed by CMS, the Division cannot renew or otherwise extend this Contract for the Contractor unless CMS determines that compelling reasons exist for doing so.

2. Contractor Responsibilities

Upon delivery by certified mail, return receipt requested, or in person to the Contractor a Notice of Termination specifying the nature of the termination, the extent to which performance of work under the contract is terminated, and the date upon which such termination becomes effective, the Contractor shall:

a. Stop work under the contract on the date and to the extent specified in the Notice of Termination;

b. Place no further orders or Subcontracts for materials, services or facilities, except as may be necessary for completion of such portion of the work in progress under the contract until the effective date of termination;

c. Terminate all orders and Subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

d. Deliver to the Division within the time frame as specified by the Division in the Notice of Termination, copies of all data and documentation in the appropriate media and make available all records required to assure continued delivery of services to beneficiaries and Providers at no cost to the Division;

e. Complete the performance of the work not terminated by the Notice of Termination;

f. Take such action as may be necessary, or as the Division may direct, for the protection and preservation of the property related to the contract which is in the possession of the Contractor and in which the Division has or may acquire an interest;

g. Fully train the Division staff or other individuals at the direction of the Division in the operation and maintenance of the process;

h. Notify the Contractor's Provider Network of the planned termination;

i. Reimburse the Division for additional costs related to mailings to Members and other stakeholders, additional Enrollment costs, additional procurement costs, attorney's fees, and Member notification;

j. Promptly transfer all information necessary for the reimbursement of any outstanding claims;

k. Promptly transfer all Member records, financial records, State and Federal data, such as encounter and quality data, and outstanding Provider and/or Member Complaints, Grievances, and Appeals; and

l. Complete each portion of the Turnover Phase after receipt of the Notice of Termination. The Contractor shall proceed immediately with the performance of the above obligations notwithstanding any allowable delay in determining or adjusting the amount of any item of reimbursable price under this clause.

The Contractor has an absolute duty to cooperate and help with the orderly transition of the duties to the Division or its designated contractor following termination of the contract for any reason.

3. Division Responsibilities

Except for termination for Contractor's default, the Division will make payment to the Contractor on termination and at Capitation Payment rate for the number of Members enrolled on the first day of the last month of operations. The Contractor shall be reimbursed for partially completed Deliverables, accepted by the Division, at a price commensurate with actual cost of performance.

In the event of the failure of the Contractor and the Division to agree in whole or in part as to the amounts to be paid to the Contractor in connection with any termination

described in this Contract, the Division shall determine on the basis of information available the amount, if any, due to the Contractor by reason of termination and shall pay to the Contractor the amount so determined.

The Contractor shall have the right of appeal, as stated under Section 15.J, Disputes, of this Contract from any such determination made by the Division.

L. **Temporary Management**

The Division can require the appointment of temporary management upon the finding by the Division that there is continued egregious behavior or substantial risk to the health of Members or to assure the health of Members during a time or for an orderly termination or reorganization of the Contractor or until improvements are made to remedy Contract violations. Temporary management cannot be terminated until the Contractor has the capability to ensure violations will not recur. If the Contractor repeatedly fails to comply with Contract provisions, the Division may impose the sanction of temporary management and give Members the right to terminate Enrollment with the Contractor.

M. **Excusable Delays**

The Contractor and the Division shall be excused from performance under this Contract for any period that they are prevented from performing any services under this Contract as a result of an act of God, war, civil disturbance, epidemic, court order, government act or omission, or other cause beyond their control. The Contractor must notify the Division within seven (7) calendar days in writing under circumstances in which the Contractor seeks an excusable delay.

N. **Obligations Upon Termination**

Upon termination of this contract, the Contractor shall be solely responsible for the provision and payment for all covered services for all Members for the remainder of any month for which the Division has paid the monthly capitation rate. Upon final notice of termination, on the date, and to the extent specified in the notice of termination, the Contractor shall:

1. Continue providing covered services to all Members until midnight on the last day of the calendar month for which a capitation rate payment has been made by the Division;

2. Continue providing all covered services to all infants of female Members who have not been discharged from the hospital following birth, until each infant is discharged;

3. Continue providing covered services to any Members who are hospitalized on the termination date, until each Member is discharged;

4. Arrange for the transfer of patients and Medical Records to other appropriate Providers as directed by the Division;

5. Supply to the Division such information as it may request respecting any unpaid claims submitted by Non-Contracted Providers and arrange for the payment of such claims within the time periods provided herein;

6. Take such action as may be necessary, or as the Division may direct, for the protection of property related to this contract, which is in the possession of the Contractor and in which the Division has or may acquire an interest; and

7. Provide for the maintenance of all records for audit and inspection by the Division or its Agents, CMS and other authorized government officials; the transfer of all data and records to the Division or its Agents as may be requested by the Division; and the preparation and delivery of any reports, forms or other documents to the Division as may be required pursuant to this contract or any applicable policies and procedures of the Division.

The covenants set forth in this section shall survive the termination of this contract and shall remain fully enforceable by the Division against the Contractor. In the event that the Contractor fails to fulfill each covenant set forth in this section, the Division shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such covenants, all at the sole cost and expense of the Contractor and the Contractor shall refund to the Division all sums expended by the Division in so doing.

SECTION 16 – FEDERAL, STATE, AND GENERAL REQUIREMENTS

The Contractor agrees that all work performed as part of this Contract will comply fully with administrative and other requirements established by federal and state laws, regulations and guidelines, and assumes responsibility for full compliance with all such laws, regulations and guidelines, and agrees to fully reimburse the Division for any loss of funds, resources, overpayments, duplicate payments or incorrect payments resulting from noncompliance by the Contractor, its staff, or agents, as revealed in any audit.

A. **HIPAA Compliance**

The Contractor shall abide by the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996, including EDI, code sets, identifiers, security, and privacy provisions as may be applicable to the services under this contract.

To the extent that the Contractor uses one or more Subcontractors or agents to provide services under this Contract, and such Subcontractors or agents receive or have access to protected health information (PHI), each such Subcontractor or agent shall sign an agreement with the Contractor that complies with HIPAA.

The Contractor shall ensure that any agents and Subcontractors to whom it provides PHI received from the Division (or created or received by the Contractor on behalf of the Division) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract. The Division shall have the option to

review and approve all such written agreements between the Contractor and its agents and Subcontractors prior to their effectiveness.

B. **Conflict of Interest**

In accordance with 1932(d)(3) of the Social Security Act, the Contractor shall comply with conflict of interest safeguards with respect to officers and employees of the Division having responsibilities relating to this Contract. Such safeguards shall be at least as effective as described in the Federal Procurement Policy Act (41 U.S.C. § 27) against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

The Contractor shall have no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Contractor shall not employ any individual or entity having any such known interests, including subsidiaries or entities that could be misconstrued as having a joint relationship, and shall not employ immediate family members of Medicaid Providers. No public official of the State of Mississippi and no official or employee of the Division, Department of Health and Human Services (DHHS), CMS or any other State or Federal agency which exercises any functions or responsibilities in the review or approval of this Contract or its performance shall voluntarily acquire any personal interest, direct or indirect, in this Contract or any Subcontract entered into by the Contractor. The Contractor hereby certifies that no officer, director, employee or agent of the Contractor, any Subcontractor or supplier and person with an ownership or control interest in the Contractor, any Subcontractor or supplier, is also employed by the State of Mississippi or any of its agencies, Division's Agent, or by DHHS, CMS or any agents of DHHS or CMS or is a public official of the State of Mississippi. In addition, such violation will be reported to the State Ethics Commission, Attorney General, and appropriate federal law enforcement officers for review. This Contract will be terminated by the Division if it is determined that a conflict of interest exists.

C. **Offer of Gratuities**

The Contractor certifies that no Member of Congress, nor any elected or appointed official, employee or Agent of the State of Mississippi, DHHS, CMS, or any other Federal agency, has or will benefit financially or materially from this Contract. This Contract will be terminated by the Division if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, its agents, employees, Subcontractors or suppliers.

D. **Contractor Status**

1. Independent Contractor

It is expressly agreed that the Contractor is an independent Contractor performing professional services for the Division and is not an officer or employee of the State of Mississippi or the Division. It is further expressly agreed that the contract shall not be construed as a partnership or joint venture between the Contractor and the

Division.

The Contractor shall be solely responsible for all applicable taxes, insurance, licensing and other costs of doing business. Should the Contractor default on these or other responsibilities jeopardizing the Contractor's ability to perform services effectively, the Division, in its sole discretion, may terminate this contract.

The Contractor shall not purport to bind the Division, its officers or employees nor the State of Mississippi to any obligation not expressly authorized herein unless the Division has expressly given the Contractor the authority to do so in writing.

The Contractor shall give the Division immediate notice in writing of any action or suit filed, or of any claim made by any party which might reasonably be expected to result in litigation related in any manner to this contract or which may impact the Contractor's ability to perform.

No other agreements of any kind may be made by the Contractor with any other party for furnishing any information or data accumulated by the Contractor under this contract or used in the operation of this program without the written approval of the Division. Specifically, the Division reserves the right to review any data released from reports, histories, or data files created pursuant to this Contract.

In no way shall the Contractor represent itself directly or by inference as a representative of the State of Mississippi or the Division of Medicaid except within the confines of its role as a Contractor for the Division of Medicaid. The Division's approval must be received in all instances in which the Contractor distributes publications, presents seminars or workshops, or performs any other outreach.

The Contractor shall not use the Division name or refer to the contract, and the services provided therein, directly or indirectly in any advertisement, news release, professional trade or business presentation without prior written approval from the Division.

2. Employment of Division Employees

The Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the contract, any professional or technical personnel who are or have been at any time during the period of the contract in the employ of the Division, without the written consent of the Division. Further, the Contractor shall not knowingly engage in this project, on a full-time, part-time, or other basis during the period of the contract, any former employee of the Division who has not been separated from the Division for at least one (1) year, without the prior written consent of the Division.

The Contractor shall give priority consideration to hiring interested and qualified adversely affected State employees at such times as requested by the Division to the extent permitted by this contract or applicable state laws, such as the Ethics in Government Act.

3. Personnel Practices

All employees of the Contractor involved in the Medicaid function will be paid as any other employee of the Contractor who works in another area of their organization in a similar position. The Contractor shall develop any and all methods to encourage longevity in Contractor's staff assigned to this contract.

Employees of the Contractor shall receive all benefits afforded to other similarly situated employees of the Contractor.

4. Property Rights

No property rights inure to the Contractor except for compensation for work that has already been performed.

E. **Provider Exclusions**

The Division will not reimburse the Contractor for services rendered by any Provider that is excluded from participation by Medicare, Medicaid, including any other states' Medicaid program, or SCHIP, including any other states' or SCHIP program, except for emergency services.

The Contractor must ensure that all their Providers and Subcontractor entities screen their employees for excluded persons. The Contractor must communicate this obligation to all Providers and Subcontractors upon credentialing and re-credentialing and upon renewal of any Subcontracts.

The Division will require the Contractor to search the following sources for names of any individual or entity upon Provider enrollment, re-enrollment, and at least monthly thereafter to capture exclusions and reinstatements: HHS-OIG's List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) Excluded Parties List Service (EPLS), CMS' Medicare Exclusion Databank (MED), the State Board of Examiners, and the System for Award Management (SAM). The process shall also include routine checks of the following databases: Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), National Practitioner Data Bank (NPDB), and Health Integrity and Protection Databank (HIPDB). These searches must include any Providers, entities and individuals with ownership or control interests in any entity to ensure that the State does not pay Federal funds to excluded Providers or entities.

The Division may impose civil monetary penalties against the Contractor if they employ or enter into a contract with excluded individuals or entities to provide items or services to Medicaid beneficiaries.

F. **Compliance with Federal Laws**

The Contractor and its Subcontractors shall comply with all applicable standards, orders or requirements issued under Section 306 for the Clean Air Act (42 USC § 1857(h)),

Section 508 of the Clean Water Act (33 USC § 1368), Executive Order 11738 and Environmental Protection Agency regulations (40 C.F.R. Part 15), which prohibit the use under non-exempt federal contracts, grants, or loans of facilities included on the EPA list of Violating Facilities. The Contractor shall report violations to the applicable grantor federal agency and the U. S. EPA Assistant Administrator for Enforcement.

The Contractor and its Subcontractors shall abide by mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conversation Contractor issued in compliance with the Energy Policy and Conservation Act (Pub. L.94-165).

The Contractor shall comply with all applicable Federal and State laws, regulations, policies, or reporting requirements needed to comply with the policies and regulations set forth in the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.

G. **Assignment**

This contract and any payments which may become due hereunder, shall not be assignable by the Contractor except with the prior written approval of the Division. The transfer of five percent (5%) or more of the beneficial ownership in the Contractor at any time during the term of this Contract shall be deemed an assignment of this contract. The Division shall be entitled to assign this Contract to any other agency of the State which may assume the duties or responsibilities of the Division relating to this contract. The Division shall provide written notice of any such assignment to the Contractor, whereupon the Division shall be discharged from any further obligation or liability under this Contract arising on or after the date of such assignment.

H. **No Waiver**

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this contract will be waived except by the written agreement of the parties, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply; and until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings, the other party shall have the right to invoke any remedy available under law or equity, notwithstanding any such forbearance or indulgence.

I. **Severability**

In the event that any provision of this contract (including items incorporated by reference) is declared to be illegal, unlawful, void, or unenforceable, then both the Division and the Contractor shall be relieved of all obligations arising under such provision. If the remainder of this contract is capable of performance, then it shall not be affected by such declaration or finding, continue in full force and effect, and all

remaining provisions shall be binding upon each party to this contract and be fully performed. If the laws or regulations governing this contract should be amended or judicially interpreted so as to render the fulfillment of this contract impossible or economically infeasible, as determined jointly by the Division and the Contractor, then both the Division and the Contractor shall be discharged from any further obligations created under the terms of this contract.

J. **Disputes**

Any disputes regarding the terms and conditions of this Contract which cannot be disposed of by agreement between the parties shall be decided by the Deputy Administrator of Health Services. Such decision shall be in writing and mailed or otherwise furnished to the Contractor. The decision of the Deputy shall be final and conclusive, unless within ten (10) calendar days following the date of such decision the Contractor mails or otherwise furnishes a written Appeal to the Division's Executive Director.

The decision of the Executive Director, or his or her duly authorized representative for the determination of such Appeals, shall be final and conclusive, unless within thirty (30) calendar days form the date of receipt of such copy, the Contractor mails or otherwise furnishes to the Attorney General a written request to render an interpretation to the Office of the Attorney General, 550 High St., Suite 1200, Jackson, Mississippi 39201. The interpretation of the Attorney General or his duly authorized representative shall be final and conclusive. The Contractor and the Division shall be afforded an opportunity to be heard and to offer evidence in support of their interpretations. Nothing in this paragraph shall be construed to relieve the Contractor of full and diligent performance of the Contract.

The Contractor shall be afforded an opportunity to be heard and to offer evidence in support of its Appeal. The Contractor shall proceed diligently with the performance of this Contract in accordance with the decision rendered by the Deputy Administrator of Health Services until a final decision is rendered by the Executive Director or his or her representative.

1. Cost of Litigation

   In the event that the Division deems it necessary to take legal action to enforce any provision of the contract, the Contractor shall bear the cost of such litigation, as assessed by the court, in which the Division prevails. Neither the State of Mississippi nor the Division shall bear any of the Contractor’s cost of litigation for any legal actions initiated by the Contractor against the Division regarding the provisions of the Contract. Legal action shall include administrative proceedings.

2. Attorney Fees

   The Contractor agrees to pay reasonable attorney fees incurred by the State and the Division in enforcing this agreement or otherwise reasonably related thereto.

K. **Proprietary Rights**

Ownership of all information and data developed, derived, documented, or furnished by the Contractor resulting from this contract resides with the Division, State of Mississippi. The Division shall have unlimited use of this information to disclose, duplicate or utilize for any purposes whatsoever.

1. Ownership of Documents

   Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings, or other graphic representation and works of any similar nature, the Division shall have the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others do so. If the material is qualified for copyright, the Contractor may copyright such material, with approval of the Division, but the Division shall reserve a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, and use such materials, in whole or in part, and to authorize others to do so.

2. Ownership of Information and Data

   The Division, the Department of Health and Human Services (DHHS), The Centers for Medicare and Medicaid Services (CMS), the State of Mississippi, and/or their agents shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Contractor under this Contract.

   The Contractor agrees to grant in its own behalf and on behalf of its agents, employees, representatives, assignees, and Subcontractors to the Division, DHHS, CMS and the State of Mississippi and to their officers, agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver, and dispose of all such information now covered by copyright of the proposed Contractor.

   Excluded from the foregoing provisions in this subsection, however, are any pre-existing, proprietary tools owned, developed, or otherwise obtained by Contractor independent of this Contract. Contractor is and shall remain the owner of all rights, title and interest in and to the Proprietary Tools, including all copyright, patent, trademark, trade secret and all other proprietary rights thereto arising under Federal and State law, and no license or other right to the Proprietary Tools is granted or otherwise implied. Any right that the Division may have with respect to the Proprietary Tools shall arise only pursuant to a separate written agreement between the parties.

3. Licenses, Patents and Royalties

   The Division does not tolerate the possession or use of unlicensed copies of proprietary software. The Contractor shall be responsible for any penalties or fines

imposed as a result of unlicensed or otherwise defectively titled software.

The Contractor, without exception, shall indemnify, save, and hold harmless the Division and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or non-patented invention, process, or article manufactured by the Contractor. The Division will provide prompt written notification of a claim of copyright or patent infringement.

Further, if such a claim is made or is pending, the Contractor may, at its option and expense, procure for the Division the right to continue use of, replace or modify the article to render it non-infringing. If none of the alternatives are reasonably available, the Contractor agrees to take back the article and refund the total amount the Division has paid the Contractor under this contract for use of the article.

If the Contractor uses any design, device, or materials covered by letters, patent or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

L. **Omissions**

In the event that either party discovers any material omission in the provisions in this contract which such party believes is essential to the successful performance of this contracts, both parties shall negotiate in good faith with respect to such matters for the purpose of making such adjustments as may be necessary to reasonably perform the objectives of this contract, provided that such adjustments do not adversely affect the interests of either party.

M. **Entire Agreement**

This Contract, together with all attachments, represents the entire agreement between the Contractor and the Division with respect to the subject matter stated herein and supersedes all other contracts and agreements between the parties.

1. Change Orders and/or Amendments

No modification or change to any provision of this contract shall be effective unless it is in writing, has the prior approval of CMS, and is signed by a duly authorized representative of the Contractor and the Division as an amendment to this contract. This Contract shall be amended whenever and to the extent required by changes in Federal or State law or regulations.

The Executive Director of the Division or designated representative may, at any time, by written order delivered to the Contractor at least thirty (30) calendar days prior to the commencement date of such change, make administrative changes within the general scope of the contract. If any such change causes an increase or decrease in the cost of the performance of any part of the work under the contract an adjustment commensurate with the costs of performance under this contract shall be

made in the Capitation Payment rate or delivery schedule or both. Any claim by the Contractor for equitable adjustment under this clause must be asserted in writing to the Division within thirty (30) calendar days from the date of receipt by the Contractor of the notification of change. Failure to agree to any adjustment shall be a dispute within the meaning of the Disputes clause of this Contract. Nothing in this clause, however, shall in any manner excuse the Contractor from proceeding diligently with the contract as changed.

Any provision of this Contract which is in conflict with Federal and State Medicaid statutes, regulations, or CMS policy guidance shall be automatically amended to conform to the provisions of those laws, regulations, and policies. Such amendment of the Contract will be effective on the effective date of the statutes or regulations necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

N. **Compliance with Mississippi Employment Protection Act (MEPA)**

Contractor represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et set of the Mississippi Code Annotated (Supp. 2008), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. Contractor agrees to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. Contractor further represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Contractor understands and agrees that any breach of these warranties may subject Contractor to the following: (a) termination of this Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Contractor by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both. In the event of such termination/cancellation, Contractor would also be liable for any additional costs incurred by the State due to contract cancellation or loss of license or permit.

O. **Employment Practices**

The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, gender, national origin, age, marital status, political affiliations, disability, genetic information, or any other consideration made unlawful by

federal, State or local laws. The Contractor must act affirmatively to ensure that employees, as well as applicants for employment, are treated without discrimination because of their race, color, religion, gender, national origin, age, marital status, political affiliation, genetic information, or disability.

Such action shall include, but is not limited to the following: employment, promotion, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment notices setting forth the provisions of this clause.

The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, gender, national origin, age, marital status, political affiliation, genetic information, or disability, except where it relates to a bona fide occupational qualification or requirement.

The Contractor shall comply with the non-discrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Order 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. The Contractor shall comply with related state laws and regulations, if any.

The Contractor shall comply with the Civil Rights Act of 1964, and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Rehabilitation Act of 1973, as amended, and the Mississippi Human Rights Act of 1977.

If the Division finds that the Contractor is not in compliance with any of these requirements at any time during the term of this Contract, the Division reserves the right to terminate this contract or take such other steps as it deems appropriate, in its sole discretion, considering the interests and welfare of the State.

P. **Lobbying**

The Contractor certifies, to the best of its knowledge and belief, that no federal appropriated funds have been paid or will be paid, by or on behalf of the Contractor to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress or an employee of a member

of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit "Disclosure Form to Report Lobbying," in accordance with its instructions.

This certification is a material representation of fact upon which reliance is placed when entering into this contract. Submission of this certification is a prerequisite for making or entering into this contract imposed under Title 31, Section 1352, and U. S. Code. Failure to file the required certification shall be subject to civil penalties for such failure.

The Contractor shall abide by lobbying laws of the State of Mississippi.

Q. **Bribes, Gratuities and Kickbacks**

The receipt or solicitation of bribes, gratuities and kickbacks is strictly prohibited.

No elected or appointed officer or other employee of the Federal Government or of the State of Mississippi shall benefit financially or materially from this contract. No individual employed by the State of Mississippi shall be permitted any share or part of this contract or any benefit that might arise therefrom.

The Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

R. **Transparency**

In accordance with the Mississippi Accountability and Transparency Act of 2008, Section 27-104-151, et seq., of the Mississippi Code of 1972, as amended, the American Accountability and Transparency Act of 2009 (P.L. 111-5), where applicable, and Section 31-7-13 of the Mississippi Code of 1972, as amended, where applicable, a fully executed copy of this agreement shall be posted to the State's accountability website at: https://www.transparency.mississippi.gov.

Unless exempted from disclosure due to a court-issued protective order, this contract is required to be posted to the Department of Finance and Administration's independent agency contract website for public access. Prior to posting the contract to the website, any information identified by the Contractor as trade secrets, or other proprietary information including confidential vendor information, or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes will be redacted.

In the event that either party to this agreement receives notice that a third party requests divulgence of confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of confidential or otherwise protected information, that party shall promptly inform the other party and thereafter respond in conformity with such subpoena to the extent mandated by State law. This provision shall survive termination or completion of this agreement. The parties agree that this provision is subject to and superseded by Miss.

Code Ann. Section 25-61-1, et seq. regarding Public Access to Public Records.

SECTION 17 – CMS

A. **Review and Approval**

This agreement is subject to review and approval by the Centers for Medicare and Medicaid Services (CMS) prior to payment for services and may be modified as required and/or suggested by CMS. Any modifications to this agreement may be enacted pursuant to the provisions described in the RFP and this agreement.

IN WITNESS WHEREOF, the parties have caused this Contract to be executed by their duly authorized representatives.

DIVISION OF MEDICAID
OFFICE OF THE GOVERNOR
STATE OF MISSISSIPPI

BY:_____

DAVID J. DZIELAK, Ph.D.
EXECUTIVE DIRECTOR

DATE:_____

MAGNOLIA HEALTH PLAN, INC.

BY:_____

JASON DEES, DO, FAAFP
PRESIDENT

DATE:_____

STATE OF MISSISSIPPI
COUNTY OF HINDS

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

GIVEN under my hand and official seal of office on this the _____ day _____ of, A.D., 2014.

NOTARY PUBLIC

My Commission Expires:

STATE OF _____
COUNTY OF_____

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, _____, in his/her official capacity as _____, who acknowledged to me, being first authorized by said corporation that he/she signed and delivered the above and foregoing written Contract for and on behalf of said corporation, and as his/her official act and deed on the day and year therein mentioned.

GIVEN under my hand and official seal of office on this the _____ day _____ of, A.D., 2014.

NOTARY PUBLIC

My Commission Expires:

EXHIBIT A: CAPITATION RATES

(Attached under a separate cover)

EXHIBIT B: EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c)(2) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including the evaluation of quality outcomes, timeliness and access to services. The requirements for EQR were further outlined in 42 C.F.R. Parts 433 and 438: External Quality Review of Medicaid Managed Care Organizations. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members.

The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight. The Division requires that the Contractor:

1. Actively participate in planning and developing the measures to be utilized with the Division and the EQRO. The Quality Leadership Team will be given an opportunity to provide input into the measures to be utilized.

2. Accurately, completely and within the required time frame identify eligible Members to the EQRO.

3. Correctly identify and report the numerator and denominator for each measure.

4. Actively encourage and require Providers, including Subcontractors, to provide complete and accurate Provider Medical Records within the time frame specified by the EQRO.

5. Demonstrate how the results of the EQR are incorporated into the Contractor's overall Quality Management Program and demonstrate progressive improvements during the term of the Contract.

6. Improve encounter data in an effort to decrease the need for extensive Provider Medical Record reviews.

7. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Parts 433 and 438.

8. Ensure that data, clinical records and workspace located at the Contractor's work site are available to the independent review team and to the Division, upon request.

EXHIBIT C: MEDICAL LOSS RATIO (MLR) REQUIREMENTS

The Contractor is required to rebate a portion of the Capitation Payment to the Division in the event the Contractor does not meet the eighty-five percent (85%) MLR standard. This Exhibit describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention 4) payment of any rebate due to the Division, and 4) monetary penalties that may be assessed against the Contractor for failure to meet requirements.

A. **Reporting Requirements**

1. General Requirements

   For each MLR Reporting Year, the Contractor must submit to the Division a report which complies with the requirements that follow concerning Capitation Payments received and expenses related to MississippiCAN Members (referred to hereafter as MLR Report).

2. Timing and Form of Report

   The report for each MLR Reporting Year must be submitted to the Division by January 1 of the year following the end of an MLR Reporting Year, in a format and in the manner prescribed by the Division.

3. Newer Experience

   If fifty percent (50%) or more of the total Capitation Payment received in an MLR Reporting Year is attributable to new Medicaid Members with less than twelve (12) months of experience in that MLR Reporting Year, then the experience of these Members may be excluded from the MLR Report. If the Contractor chooses to defer reporting of newer business, then the excluded experience must be added to the experience reported in the following MLR Reporting Year.

4. Capitation Payments

   A Contractor must report to the Division the total Capitation Payments received from the Division for each MLR Reporting Year. Total Capitation Payments means all monies paid by the Division to the Contractor for providing benefits and services as defined in the terms of the Contract.

B. **Reimbursement for Clinical Services Provided to Members**

The MLR Report must include direct claims paid to or received by 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." Specific requirements include:

1. Incurred claims must include changes in unpaid claims between the prior year's and the current year's Unpaid Claims Reserves, including claims reported in the process

of adjustment, percentage withholds from payments made to subcontracted Providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

2. Incurred claims must include the change in claims incurred but not reported from the prior year to the current year. Except where inapplicable, the reserve should be based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

3. Incurred claims must include changes in other claims-related reserves.

4. Incurred claims must exclude rebates paid to the Division based upon prior MLR Reporting Year experience.

5. Adjustments to incurred claims:

   a. Adjustments that must be deducted from incurred claims:

      i. Prescription drug rebates received by the Contractor

      ii. Overpayment recoveries received from Providers

   b. Adjustments that may be included in incurred claims:

      i. The amount of incentive and bonus payments made to Providers

   c. Adjustments that must not be included in incurred claims:

      i. Amounts paid to third party vendors for secondary network savings

      ii. Amounts paid to third party vendors for network development administrative fees, claims processing, and utilization management

      iii. Amounts paid, including amounts paid to a Provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to a Member. For example, Medical Record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and Medical Record clerks must not be included in incurred claims.

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

1. General Requirements

   The MLR may include expenditures for activities that improve health care quality, as described in this section.

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 Contract;

(b) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;

(c) Quality reporting and documentation of care in non-electronic format;

(d) Health information technology to support these activities;

vi. Accreditation fees directly related to quality of care activities;

vii. Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

(a) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;

(b) Patient-centered education and counseling;

(c) Personalized post-discharge reinforcement and counseling by an appropriate health care professional;

(d) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and,

(e) Health information technology to support these activities;

viii. 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 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.

ix. Implement, promote, and increase wellness and health activities. Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include:

(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) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in payments or claims;

(e) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(f) Coaching or education programs and health promotion activities designed to change Member behavior and conditions (for example, smoking or obesity); and,

(g) Health information technology to support these activities.

x. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

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 share of expenses that are for lines of business or products other than Mississippi Medicaid;

c. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from Division Capitation Payments;

d. Those activities that can be billed or allocated by a Provider for care delivery and which are, therefore, reimbursed as clinical services;

e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements);

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, other than Fraud detection/recovery expenses up to the amount recovered that reduces incurred claims;

i. The cost of developing and executing Provider contracts and fees associated with establishing or managing a Provider Network, including fees paid to a vendor for the same reason;

j. Provider credentialing;

k. Marketing expenses;

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

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

n. State and Federal taxes and regulatory fees; and,

o. Any function or activity not expressly included in paragraph three (3) of this section, unless otherwise approved by and within the discretion of the Division, upon adequate showing by the Contractor that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

D. **Expenditures Related to Health Information Technology and Meaningful Use Requirements**

1. General Requirements

A Contractor may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities that are designed for use by the Contractor, contracted Providers, or Members for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with HHS meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

a. Making incentive payments to health care Providers for the adoption of certified electronic health record technologies and their ``meaningful use'' as defined by HHS to the extent such payments are not included in reimbursement for clinical services;

b. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care Providers, including those not eligible for Medicaid incentive payments;

c. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

d. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA, URAC, or JCAHO, or costs for reporting to the Division on quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS® surveys or chart review of HEDIS® measures);

e. 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;

f. 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,

g. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

E. **Other Non-Claims Costs**

1. General Requirements

The MLR Report must include non-claims costs described in paragraph two (2) of this section and must provide an explanation of how Capitation Payments are used, other than to provide reimbursement for clinical services included in core benefits and services, expenditures for activities that improve health care quality, and expenditures related to health information technology and meaningful use requirements.

2. Non-Claims Costs Other

The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation 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.

F. **Allocation of Expenses**

1. General Requirements

Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit lines of business other than Mississippi Medicaid must be reported on a pro rata share.

2. Description of the 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, and other non-claims costs resulting from Contractor activities in Mississippi. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

a. Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the Contractor must provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses;

b. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense; and,

c. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, Capitation Payment ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the

reporting entity and are not to be apportioned to other entities within a group.

3. Maintenance of Records

The Contractor must maintain 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 paragraph two (2) of this section were accurately implemented in preparing the MLR Report.

G. **Formula for Calculating Medical Loss Ratio**

1. Medical Loss Ratio

a. A Contractor's MLR is the ratio of the numerator and the denominator, as defined:

i. The numerator of the Contractor's MLR for an MLR Reporting Year must be the Contractor's incurred claims plus the Contractor's expenditures for activities that improve health care quality.

ii. The denominator of the Contractor's MLR must equal the Contractor's Capitation Payments received from the Division reduced by amounts allocated for premium taxes, Health Insurer Tax, and other revenue-based assessments as determined by the Division.

b. A Contractor's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

2. Rebating Capitation Payments if the eighty-five percent (85%) Medical Loss Ratio Standard is Not Met

a. General Requirement

For each MLR Reporting Year, the Contractor must provide a rebate to the Division if the Contractor's MLR does not meet or exceed the eighty-five percent (85%) requirement.

b. Amount of Rebate

For each MLR Reporting Year, the Contractor must rebate to the Division the difference between the total amount of Capitation Payments received by the Contractor from the Division multiplied by the required MLR of eighty-five percent (85%) and the Contractor's actual MLR.

c. Timing of Rebate

The Contractor must provide any rebate owing to the Division no later than February 1 following the end of the MLR Reporting Year.

d. Late Payment Interest

The Contractor that fails to pay any rebate owing to the Division in accordance within the time periods set forth in this Exhibit must, in addition to providing the required rebate to the Division, 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 February 1.

EXHIBIT D: MEMBER COMPLAINT, GRIEVANCE, APPEAL, AND STATE FAIR HEARING PROCESS

A. General Requirements

The Contractor's Member Grievance and Appeal procedures shall meet the following requirements:

1. Resolving Grievances and Appeals expeditiously by Contractor personnel at a decision-making level with authority to require corrective action.

2. Providing for separate tracks for administrative and utilization management Grievances and Appeals.

3. Describing procedures for the submission and resolution of a Grievance or Appeal and request for a State Fair Hearing.

4. Maintaining written documentation of each Complaint, Grievance, Appeal, and the actions taken by the Contractor.

5. Distributing a written description and educating contracted Providers of the Contractor's Grievance and Appeal process and how Providers can submit a Grievance or Appeal for a Member, or on their own behalf.

6. Making available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

7. Designating a specific individual as the Contractor's Medicaid Member Grievances and Appeals coordinator with the authority to administer the policies and procedures for resolution of a Grievance or Appeal, to review patterns/trends in Grievances and Appeals, and to initiate corrective action.

8. Ensuring that the individuals who make decisions on Grievances or Appeals are not involved in any previous level of review or decision-making. The Contractor shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

    a. An Appeal of a Contractor denial that is based on lack of medical necessity;

    b. A Contractor denial that is upheld in an Expedited Resolution; and

    c. A Grievance or Appeal that involves clinical issues.

9. Ensuring that punitive or retaliatory action is not taken against a Member or service Provider that files a Grievance or an Appeal, or a Provider that supports a Member's Grievance or Appeal.

10. Ensuring that there is a link between the Complaint, Grievance, and Appeal processes and the Quality Management and Utilization Management programs.

11. Designating and training sufficient staff to be responsible for receiving, processing, and responding to Complaints, Grievances, and Appeals in accordance with the requirements in this Exhibit and Contract.

12. Conducting an additional Provider office visit within forty-five (45) calendar days when a Complaint, Grievance, and/or Appeal threshold has been met against a specific Provider which relates to the Provider's office.

The following parties have a right to file a Grievance and Appeal on behalf of the Member:

1. The legal guardian of the Member for a minor or an incapacitated adult,

2. A representative of the Member as designated in writing to the Contractor, or

3. A service Provider acting on behalf of the Member and with the Member's written consent.

All notices sent to Members must comply with 42 C.F.R. § 438.404(a). Notices indicating the resolution of Grievances and Appeals must be in writing and must meet the language and format requirements of 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding. The notice must explain the following:

1. Action the Contractor has taken or intends to take (e.g., disposition of the Grievance or Appeal).

2. Reasons for the action (e.g., findings and conclusions based on the investigation, all information considered in investigating the Grievance or Appeal).

3. Member's or the Provider's right to file an Appeal with the Contractor.

4. Member's right to request a State Fair Hearing.

5. Procedures for exercising Appeal rights.

6. Circumstances under which Expedited Resolution is available and how to request it.

7. Member's right to have benefits continue pending resolution of the Appeal and/or State Fair Hearing, how to request that benefits be continued, and circumstances under which the Member may be required to pay the costs of these services.

B. **Complaint:** An expression of dissatisfaction received orally that is of a less serious or formal nature that is resolved within one (1) business day of receipt. Any Complaint not resolved within one (1) business day shall be treated as a Grievance. A Complaint includes, but is not limited to, inquiries, matters, misunderstandings, or misinformation

that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.

A Member may file a Complaint either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction.

The Contractor shall have procedures for receiving, responding to, and documenting resolution of Member Complaints within one (1) business day of receipt do not require a formal written response or notification.

The Contractor shall contact the Member within twenty-four (24) hours of the initial contact via telephone if the Contractor is unavailable for any reason or the matter cannot be readily resolved during the initial contact. Any Complaint that is not resolved within one (1) business day shall be treated as a Grievance, in accordance with requirements set forth below.

C. **Grievance:** An expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor Action as defined in this Contract. A Grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness or a Provider or an employee, or failure to respect the Members rights.

A Member may file a Grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction.

Within ten (10) business days of receipt of the Grievance, the Contractor shall provide the grievant with written notice that the Grievance has been received and the expected date of its resolution. For telephonic Grievances received, the Contractor may provide grievant with verbal notice of expected date of resolution. If requested by the Member or his/her representative, a written resolution will be provided.

The investigation and final Contractor resolution process for Grievances shall be completed within thirty (30) calendar days of the date the Grievance is received by the Contractor, or as expeditiously as the Member's health condition requires, and shall include a resolution letter to the grievant.

The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two (2) business days of the decision to extend the time frame.

Upon resolution of the Grievance, the Contractor shall mail a resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred above, unless the resolution of the Grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the Grievance.

D. **Appeal:** A request for review by the Contractor of a Contractor Action.

A Member may file an Appeal either orally or in writing of a Contractor Action within thirty (30) calendar days of receiving the Contractor's notice of Action. The Contractor shall consider the Member, representative, or estate representative of a deceased Member as parties to the Appeal.

The Contractor has forty-five (45) calendar days from the date the initial verbal or written Appeal is received by the Contractor to resolve the Appeal, or as expeditiously as the Member's health condition requires. The Contractor shall appoint at least one (1) person to review the Appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision. Within this same forty-five (45) calendar day time frame, the Contractor shall provide written notice to the Member and/or Provider, if the Provider filed the Appeal.

Within ten (10) calendar days of receipt of the Appeal, the Contractor shall provide the grievant with written notice that the Appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of verbal Appeals, unless the Member or the service Provider requests an Expedited Resolution.

The Contractor shall have a process in place that ensures that a verbal or written inquiry from a Member seeking to Appeal an Action is treated as an Appeal (to establish the earliest possible filing date for the Appeal). A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date. The Contractor shall use its best efforts to assist Members as needed with the written Appeal and may continue to process the Appeal.

The Contractor may extend the forty-five (45) calendar day time frame by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two (2) business days of the decision to extend the time frame.

The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

The Contractor shall provide the Member or the representative the opportunity, before and during the Appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the Appeals process. The Contractor shall include as parties to the Appeal the Member and his or her representative, or the legal representative of a deceased Member's estate.

The Contractor shall continue the Member's benefits if all of the following are met:

1. Member or the service Provider files a timely Appeal of the Contractor Action (timely filing means within ten (10) days of the Contractor notice of Action) or the

Member asks for a State Fair Hearing within thirty (30) calendar days from the date on the Contractor notice of Action;

2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. The services were ordered by an authorized service Provider;

4. The time period covered by the original authorization has not expired; and

5. Member requests extension of the benefits.

The Contractor shall provide benefits until one of the following occurs:

1. The Member withdraws the Appeal;

2. Ten (10) calendar days have passed since the date of the notice, provided the resolution of the Appeal was against the Member and the Member has not requested a State Fair Hearing or taken any further Action;

3. The Division of Medicaid issues a State Fair Hearing decision adverse to the Member; and

4. The time period or service limits of a previously authorized service has expired.

If the final resolution of the Appeal is adverse to the Member, that is, the Contractor's Action is upheld, the Contractor may recover the cost of the services furnished to the Member while the Appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 C.F.R. § 431.230(b).

If the Contractor or the Division reverses a decision to deny, limit, or delay services, and these services were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the Contractor or the Division of Medicaid reverses a decision to deny, limit or delay services and the Member received the disputed services while the Appeal was pending, the Contractor shall pay for these services.

E. **Expedited Resolution of Appeals:** An expedited review by the Contractor of a Contractor Action.

The Contractor shall establish and maintain an expedited review process for Appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Such a determination is based on:

1. A request from the Member;

2. A Provider's support of the Member's request;

3. A Provider's request on behalf of the Member; or

4. The Contractor's independent determination.

The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.

The Contractor shall resolve the Appeal within three (3) business days of receipt of the request for an expedited Appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document verbal notice.

The Contractor may extend the time frame by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Division that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.

The Contractor shall ensure that punitive Action is not taken against a Member or a service Provider who requests an Expedited Resolution or supports a Member's expedited Appeal.

The Contractor shall provide an Expedited Resolution, if the request meets the definition of an expedited Appeal, in response to a verbal or written request from the Member or service Provider on behalf of the Member.

The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.

If the Contractor denies a request for an Expedited Resolution of an Appeal, it shall:

1. Transfer the Appeal to the forty-five (45) calendar day time frame for standard resolution, in which the forty-five (45) calendar day period begins on the date the Contractor received the original request for Appeal; and

2. Make reasonable efforts to give the Member prompt verbal notice of the denial, and follow up with a written notice within two (2) calendar days.

The Contractor shall document in writing all verbal requests for Expedited Resolution and shall maintain the documentation in the case file.

F. **State Fair Hearing:** A hearing conducted by the Division of Medicaid or its Subcontractor in accordance with 42 C.F.R. Part 431, Subpart E.

A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor within thirty (30) calendar days of the final decision by the Contractor. The Member must exhaust all CCO level Grievance and

Appeal procedures prior to requesting a State Fair Hearing with the Division of Medicaid.

For Member Appeals, the Contractor is responsible for providing to the Division and to the Member an Appeal summary describing the basis for the denial. For standard Appeals, the Appeal summary must be submitted to the Division and the Member at least ten (10) calendar days prior to the date of the hearing. For expedited Appeals, (that meet criteria set forth in 42 C.F.R. § 438.410 the Appeal summary must be faxed to the Division and faxed or overnight mailed to the Member, as expeditiously as the Member's health condition requires, but no later than four (4) business hours after the Division informs the Contractor of the expedited Appeal. The Division may require that the Contractor attend the hearing either via telephone or in person. The Contractor is responsible for absorbing any telephone/travel expenses incurred. These records shall be made available to the Member upon request by either the Member or the Member's legal counsel. In addition, the Division will provide the Member with a hearing process that shall adhere to 42 C.F.R Part 438, Subpart F and 42 C.F.R. Part 431, Subpart E.

Failure of the Contractor to comply with the State Fair Hearing requirements of the State and Federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.

The Contractor shall educate its Members of their right to Appeal directly to the Division. The Member must exhaust all CCO level Grievance and Appeal procedures prior to requesting a State Fair Hearing with the Division.

Any adverse Action or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's authorized representative to the Division for a State Fair Hearing conducted in accordance with 42 CFR Part 431, Subpart E. Adverse actions include reductions in service, suspensions, terminations, and denials. Furthermore, the Contractor's denial of payment for Mississippi Medicaid covered services and failure to act on a request for services within required time frames may also be appealed. Appeals must be requested in writing by the Member or the Member's representative within thirty (30) calendar days of the Member's receipt of notice of adverse Action unless an acceptable reason for delay exists. An acceptable reason shall include, but not be limited to, situations or events where:

1. Appellant was seriously ill and was prevented from contacting the Contractor;

2. Appellant did not receive notice of the Contractor's decision;

3. Appellant sent the request for Appeal to another government agency in good faith within the time limit; and

4. Unusual or unavoidable circumstances prevented a timely filing.

The Contractor shall comply with the Division's State Fair Hearing decision. The Division's decision in these matters shall be final and shall not be subject to Appeal by the Contractor.

EXHIBIT E: NON-EMERGENCY TRANSPORTATION (NET) REQUIREMENTS

The Contractor, in its delivery of NET services, shall comply with all requirements of Exhibit H, Reporting Requirements, of this Contract.

The Contractor shall administer and provide NET services to Members, including but not limited to the establishment of a network of NET Providers, and authorization, coordination, scheduling, management, and reimbursement of NET service requests.

The Contractor is required to provide NET services according to Division policies. The Division will provide assistance as needed with interpretation and clarification of Division policy and will notify the Contractor as changes are made that affect the NET Program.

The Contractor will be responsible for reimbursing NET Providers. The Contractor is not required to reimburse for unauthorized NET services provided by Non-Contracted Providers.

The Contractor shall meet with the Division as needed throughout the term of the Contract to discuss and resolve administrative and operational issues. Meetings may be conducted in person, by teleconference or by videoconference.

The Contractor shall develop written policies and procedures that describe how the Contractor, in the delivery of NET services, shall comply with the requirements of the Agreement, including this Exhibit.

A. **NET Service Requests**

Requests for NET services may be made by Members; their family members, guardians or representatives; and by Providers. The Contractor shall screen all NET requests to determine each of the following items:

1. The Member's medical need which requires NET services;

2. The Member's lack of access to available transportation. The Contractor shall require the Member to verbally certify this lack of access;

3. The medical service for which NET service is requested is a covered medical service;

4. The most economical mode of transportation appropriate to meet the medical needs of the Member, based on the Member's mobility status and personal capabilities on the date of service. The Contractor must document in detail the reasons for approval of a mode of transportation that is not the most economical;

5. Close proximity of Provider to the Member; and

6. Necessity of attendant or assistance request. The Contractor may require a medical certification statement from the Member's physician in order to approve door-to-door service or hand-to-hand service.

The Contractor shall educate Members on how to request NET services. The Contractor shall instruct Members that requests for NET services must be made at least three (3) business days before the NET service is needed. Because scheduling issues will occasionally occur, the Contractor must develop processes for handling urgent trips, last minute requests from Members, scheduling changes, and NET Providers who do not arrive for scheduled pick-ups. The Contractor shall provide additional education to Members who habitually request transportation less than two (2) business days in advance of the appointment date.

B. **Prior Authorizations and Denials**

If the Contractor receives a request for NET services that meets one of the denial reasons listed below, the Contractor shall deny the request and record the reason(s) for the denial in its information system on the same business day. The Contractor shall generate and mail denial letters to Members no later than the next business day following the date the denial decision was made. The denial letter shall notify the Members of the right to Appeal the denial. All costs of generating and sending denial notices shall be borne by the Contractor. In the event a Member does not have sufficient information to arrange the transport and has to hang up and call back at a later time, the initial phone call with incomplete information will not be considered a trip denial for reporting purposes.

Denial reasons include:

1. The Member does not have a medical need that requires NET services;

2. The medical service for which NET service is requested is not a covered medical service;

3. The Member has access to available transportation;

4. The request was for post-transportation Authorization and was not received timely or did not meet established criteria;

5. The medical appointment is not scheduled or was not kept;

6. The Contractor cannot confirm that the Member had a medical appointment;

7. The Contractor cannot accommodate the request as the trip was not requested timely;

8. The Contractor requested additional documentation which was not received timely;

9. The Member refuses the appropriate mode of transportation; or

10. The Member refuses the NET Provider assigned to the trip and another appropriate NET Provider is not available.

The Contractor shall authorize and schedule routine NET services for ninety-eight percent (98%) of all requests within three (3) business days after receipt of the request.

Contractor shall authorize and schedule routine NET services for one hundred percent (100%) of all requests within ten (10) business days after receipt of a request. The Contractor shall report these requirements to the Division via a monthly Deliverable report.

If the Contractor requires additional information to authorize a request, the Contractor shall place the request on hold and shall request the additional information within twenty-four (24) hours after receipt of the request. The Contractor shall specify the date by which the additional information must be submitted. Timely requests by the Contractor for additional information shall stay the authorization period. If the Contractor does not receive additional information by the date specified by the Contractor, the Contractor shall deny the request except NET services to an appointment for chemotherapy, dialysis, and high-risk pregnancy. In those instances, the Contractor shall authorize Single Trips and pursue receipt of necessary information to authorize a Standing Order.

C. **Appropriate Type of Transportation**

Table 10 outlines the modes of transportation the Contractor must use to provide NET services to Members.

Table 10. Modes of Transportation

Mode	Description
Fixed Route	Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule, and picks up passengers at designated stops.
Basic Vehicle	A motorized vehicle used for the transportation of passengers whose medical condition does not require use of a wheelchair, hydraulic lift, stretcher, medical monitoring, medical aid, medical care or medical treatment during transport. This does not include Private Auto.
Enhanced Vehicle	A motorized vehicle equipped specifically with certified wheelchair lifts or other equipment designed to carry persons in wheelchairs or other mobility devices, or is equipped specifically for the transportation of passengers who cannot sit upright and are required to remain in a lying position during transport. Enhanced Vehicles can only be used to transport passengers that do not require medical monitoring, medical aid, medical care or medical treatment during transport. This does not include Private Auto.
Non-Emergency Ambulance	A motorized vehicle equipped specifically for the transportation of a passenger whose medical condition requires transfer by stretcher with medical supervision. The patient's condition may also require the use of medical equipment, monitoring, aid, care or treatment, including the administration of drugs or oxygen, during the transport.

Mode	Description
Other Transportation	Any commercial carrier, such as Amtrak, buses (such as Greyhound) or airplanes.

The Contractor is encouraged to maximize the utilization of fixed route transportation whenever more economical and appropriate. The Contractor shall be familiar with schedules of fixed route transportation in communities where it is now available and in areas where it becomes available during the term of the Contract. The Contractor shall distribute or arrange for the distribution of fixed route passes to Members for whom fixed route transportation is the most appropriate mode of transportation.

The furthest distance a Member may be required to walk to or from a fixed route transportation stop is one quarter (1/4) mile. If the Contractor determines that fixed route transportation is an appropriate mode of transportation for a Member, but the Member requests a different mode of transportation, the Contractor may require the Member to verify his or her mobility limitations, including, but not limited to, requiring the Member to supply documentation from his or her physician. The Contractor shall consider the following when determining whether to allow an exception:

a. The Member's ability to travel independently, including the age of the Member, and any permanent or temporary debilitating physical or mental condition that precludes use of fixed route transportation;

b. The availability of the fixed route transportation in the Member's area or community, including the accessibility of the location to which the Member is traveling and whether the Member must travel more than one quarter (1/4) of a mile to or from the fixed route transportation stop;

c. Inclement weather conditions (including extreme heat or cold) or other pertinent factors that make use of fixed route transportation unfeasible;

d. The compatibility of the fixed route transportation schedule with the Member's appointment times for the covered medical service. The schedule of the fixed route transportation should allow the Member to arrive at the drop off location no more than sixty (60) minutes prior to the scheduled appointment time, and will allow the Member forty-five (45) minutes after the estimated time the appointment will end to arrive at the pick-up location; and

e. Any special needs of the Member that requires the coordination of services with other Providers.

1. Trip Type

   Table 11 outlines requirements for specific types of trips to be used by the Contractor to provide NET services to Members.

Table 11. Types of Transportation

Mode	Description
Single Trip Request	The Contractor shall require that requests for NET service to a single appointment be made via the Member Services Call Center. Other methods of single trip requests may be allowed with Division approval.
Standing Order Trip Requests	The Contractor shall establish procedures to handle trip requests so that Members are not required to continually arrange for repetitive appointments. The Contractor shall include in its procedure to recertify the need of a Standing Order with the Medical Provider at least every ninety (90) calendar days. These orders may be accepted via phone, fax, or a web-based reservation system.
Emergency Transports	In limited situations, a Member may be transported by emergency medical air ambulance (fixed-wing or helicopter) or emergency medical ground ambulance to a medical facility. Upon discharge, if the Member can be transported home via an ambulatory vehicle, wheelchair accessible vehicle, or commercial air, the Contractor shall make the appropriate arrangements for the one-way transport for the Member and up to one (1) attendant.

D. **Network of NET Providers**

The Contractor shall establish a network of NET Providers and negotiate reimbursement with qualified transportation entities. The Contractor is encouraged to develop innovative and creative strategies to reduce per trip costs such as providing reimbursement for gasoline and making greater use of fixed-route public transportation.

The Contractor shall identify, recruit, and negotiate contracts with NET Providers, including all Modes of Transportation, sufficient to meet the needs of Members. The Contractor shall secure sufficient NET Provider resources (numbers and types of vehicles, drivers) under contracts so that the failure of any NET Provider to perform will not impede the ability of Contractor to provide NET services in accordance with the requirements of the Contract.

1. NET Provider Contracts

   The Contractor shall receive advance written approval from the Division for the model contract the Contractor intends to use with NET Providers. The model contract shall address, at a minimum, the following items:

   a. Identification of the NET Provider;

   b. Payment administration and timely payment;

c. Modes of transportation;

d. Geographic coverage area(s);

e. Attendant services;

f. Telephone and vehicle communication systems

g. Information systems;

h. Scheduling;

i. Dispatching;

j. Pick-up and delivery standards;

k. Urgent Trip requirements;

l. Driver qualifications;

m. Expectations for Door to Door, Hand to Hand, Curb to Curb;

n. Driver conduct;

o. Driver manifest delivery;

p. Vehicle requirements;

q. Back-up service;

r. Quality assurance;

s. Non-compliance with standards;

t. Training for drivers;

u. Confidentiality of Information;

v. Specific provision, that in the instance of default by Contractor, the agreement will pass to the Division or its Agent for continued provision of NET services. All terms, conditions and rates established by the agreement shall remain in effect until or unless renegotiated with the Division or its Agent subsequent to default action or unless otherwise terminated by the Division at its sole discretion;

w. Indemnification language to protect the State of Mississippi and the Division;

x. Evidence of insurance for vehicle and driver;

y. Submission of documentation as required by the Division; and

z. The procedures for Appeal and dispute resolution.

E. **Notification and Dispatch of Trips**

If possible, the Contractor shall inform the Member or the Member's representative of the transportation arrangements during the phone call requesting the NET service. Otherwise, the Contractor shall inform the Member or representative by later phone call, by facsimile, or by letter. If the Contractor sends a letter, the letter shall be mailed in time to be received by the Member prior to the date of NET service.

The Contractor shall receive requests for NET services; screen each request and, if authorized; schedule and assign the trip to an appropriate NET Provider. The Contractor should strive to maintain existing relationships between NET Providers and Members, and should try to accommodate a Member's request for a specific NET Provider in the Contractor's network, especially in the transportation of Members with disabilities. The following standards must be maintained.

1. The Contractor shall ensure that the average waiting time for pick-up does not exceed fifteen (15) minutes. The Contractor shall ensure that Members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return trip if the covered medical service follows a reliable schedule. The pre-arranged times may not be changed by the NET Provider or driver without prior permission from the Contractor.

2. The Contractor shall require NET Providers to make his or her presence known to the Member and wait until at least five (5) minutes after the scheduled pick-up time. If the Member is not present for pick up, the driver shall notify the NET Provider's dispatcher before departing from the pick-up location. NET Providers cannot change the assigned pickup time without permission from the Contractor. If the NET Provider cannot arrive on time to the pick-up location, the NET Provider or Contractor shall contact the Member or the Member's representative and the Provider. No more than two percent (2%) of the scheduled trips shall be late or missed per day.

3. The Contractor and a NET Provider may group Members and trips to promote efficiency and cost effectiveness. The Contractor may contact Providers in this process.

4. For multi-passenger trips, trips should be scheduled so that a Member does not remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for direct transportation of that Member.

5. The Contractor shall notify the NET Provider of the assignment at least two (2) business days prior to the trip, if possible, and shall timely assign the trip to another NET Provider if necessary.

6. The Contractor shall contact an appropriate NET Provider so that pick-up occurs within three (3) hours of a hospital discharge.

The Contractor shall report the above requirements to the Division via a monthly Deliverable report.

F. **Vehicle Requirements**

Vehicles shall comply with the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation. The Contractor shall supply all NET Providers with a copy of the ADA vehicle requirements and inspect the vehicles for compliance. Vehicles used for transporting Members with Disabilities must comply with applicable ADA vehicle requirements in order to be approved for use. Vehicles shall also comply with all Federal, State, county or local requirements; and the requirements listed below. All vehicles used for transport must:

1. Not exceed the vehicle manufacturer's approved seating capacity for the number of persons in the vehicle, including the driver.

2. Have adequately functioning heating and air-conditioning systems and shall maintain a temperature at all times that is comfortable to the Member at all times.

3. Have functioning seat belts and restraints as required by Federal, State, county or local statute or ordinance and:

    a. Have an easily visible interior sign that states "ALL PASSENGERS MUST WEAR SEAT BELTS."

    b. Seat belts must be stored off the floor when not in use.

    c. Have at least two (2) seat belt extensions available.

    d. Be equipped with at least one (1) seat belt cutter that is kept within easy reach of the driver for use in emergency situations.

4. Have an accurate, operating speedometer and odometer.

5. Have two (2) exterior rear view mirrors, one (1) on each side of the vehicle.

6. Be equipped with an interior mirror for monitoring the passenger compartment.

7. Have a clean exterior free of broken mirrors or windows, excessive grime, major dents or paint damage that detract from the overall appearance of the vehicles.

8. Have a clean interior free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items.

9. Be operated within the manufacturer's safe operating standards at all times.

10. Display the NET Provider's business name and telephone number in a minimum of three (3) inch high lettering in a color that contrasts with the surrounding background on at least both sides of the exterior of the vehicle and must not have:

    a. Words displayed on the interior or exterior of the vehicle indicating that Medicaid Members are being transported; or

    b. A NET Provider's business name which implies Medicaid Members are being transported.

11. Have the vehicle license number and Contractor's toll-free and local phone number prominently displayed on the interior of each vehicle. This information and the Complaint procedures shall be clearly visible and available in written format in each vehicle for distribution to Members upon request.

12. Be non-smoking at all times, including when a Member is not present in the vehicle, with a visible interior sign that states "NO SMOKING."

13. Have a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.

14. Be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves and sterile eyewash.

15. Contain a current map or GPS system of the applicable geographic area with sufficient detail to locate Member and Provider addresses.

16. Be equipped with an appropriate working fire extinguisher stored in a safe location.

17. Have insurance coverage for all vehicles at all times during the Contract period in compliance with State law, and any county or city ordinance.

18. Be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.

19. Be equipped with a real-time link, phone or two-way radio. Pagers are not acceptable as a substitute.

Each Wheelchair Vehicle with a mechanical lift must have an engine-wheelchair lift interlock system, which requires the transmission to be placed in park, and emergency brake engaged to prevent vehicle movement when the lift is deployed. All wheelchair lifts must meet current ADA guidelines. Each Wheelchair Vehicle shall have, for each wheelchair position, a wheelchair securement device (or "tie-down") which meets current ADA guidelines.

The Contractor shall document the lifting capacity of each vehicle in its network in order

to route trips to NET Providers that have appropriate lift capacity for Members. The Contractor shall also have in its network NET Providers that have the capability to perform bariatric transports of patients up to eight hundred (800) pounds.

G. **Vehicle Inspection**

The Contractor shall inspect all NET Providers' vehicles prior to the Operations Start Date and at least every six (6) months thereafter. The Contractor shall ensure that NET Providers maintain all vehicles to meet or exceed local, State, and Federal requirements, and manufacturer's safety, mechanical, operating, and maintenance standards. In addition, the Contractor shall test all communication equipment during regularly scheduled vehicle inspection.

Upon completion of a successful inspection, an inspection sticker approved by the Division shall be applied to the vehicle. The Contractor shall place the inspection sticker on the outside of the passenger side rear window in the lower right corner.

Authorized employees of the Contractor shall immediately remove from service any vehicle or driver found to be out of compliance with these requirements, or with any State or Federal regulations. The vehicle or driver may be returned to service only after Contractor verifies that the deficiencies have been corrected. Any deficiencies, and actions taken to remedy deficiencies, shall be documented and become a part of the vehicle's and the driver's permanent records.

The Contractor shall submit the final plan for vehicle inspection, forms, inspection sticker and a list of trained inspectors to the Division at least thirty (30) calendar days prior to the Operations Start Date. The plan shall include the names of all employees or Subcontractors who are authorized to inspect the vehicles for Contractor. Inspection forms must have a checklist that includes all the appropriate vehicle inspection requirements of the Contract and of local, State and Federal law.

H. **Driver Requirements**

All drivers and NET Providers shall abide by State and local laws and meet the following requirements:

1. The Contractor must require all NET Providers comply with Mississippi Statutes regarding criminal background checks, including but not limited to, fingerprinting and verifying the driver is not listed on the Mississippi Sex Offender Registry and ensure excluded persons or entities are not paid any state or Federal funds.

2. Drivers must:

    a. Abide by State, Federal and local laws.

    b. Be at least eighteen (18) years of age and have a current valid driver license to operate the assigned vehicle.

c. Be courteous, patient and helpful to all passengers.

d. Be neat and clean in appearance.

e. Wear a visible, easily read nametag which identifies the employee and the employer.

f. Provide an appropriate level of assistance to a Member when requested or when necessitated by the Member's mobility status or personal condition, including Curb-to-Curb, Door-to-Door and Hand-to-Hand assistance, as required.

g. Must confirm the Member is safely inside the residence or facility before departing the drop-off point.

h. Is responsible for properly securing any mobility devices used by the Member.

i. Assist Members in the process of being seated, confirm all seat belts are fastened properly and all passengers are safely and properly secured.

j. Park the vehicle in a safe location out of traffic if a Member or other passenger's behavior or any other condition impedes the safe operation of the vehicle; notify the dispatcher and request assistance.

k. Prevent the Member from crossing streets to reach the entrance of their destination.

l. Must provide verbal directions to passengers, as appropriate.

m. Notify the NET Provider immediately to report an emergency such as an accident and/or incident or vehicle breakdown to arrange for alternative transportation for the Members on board. The NET Provider must report all accidents/incidents and breakdowns to the Contractor.

n. Report all no-shows immediately to the NET Provider and the NET Provider must notify the Contractor so the authorization can be cancelled.

3. Drivers must not:

a. Leave a Member unattended at any time.

b. Use alcohol, narcotics, illegal drugs, or prescription medications that impair their ability to perform.

c. Smoke in the vehicle, at any time or smoke while assisting a Member or in the presence of the Member. Members or their adult attendant cannot smoke in the vehicle.

d. Wear any type of headphones while on duty, with the exception of hands-free headsets for mobile telephones which can only be used for communication with

the NET Provider or to call 911 in an emergency.

e. Touch any passenger except as appropriate and necessary to assist the passenger into or out of the vehicle, into a seat and to secure the seatbelt or as necessary to render first aid or assistance which the driver has been trained.

4. Drivers must be removed from services if they:

   a. Fail an annual random drug test;

   b. Are convicted of two (2) moving violations or accidents related to transportation provided under NET; or

   c. Have a suspended or revoked driver's license for moving traffic violations in the previous five (5) years.

5. Contractor Driver Requirements

   The Contractor must ensure NET Providers employ drivers in accordance with or exceeding local, State and Federal requirements and the Mississippi Administrative Code. The Contractor must supply NET Providers with a copy of the driver requirements and inspect the NET Provider employee records prior to the Operations Start Date and at least every six (6) months thereafter. The Contractor must maintain records of bi-annual inspections and make them available to the Division via a quarterly Deliverable report.

I. **Trip Monitoring**

The Contractor shall require that the NET Providers' drivers to maintain daily trip logs containing, at a minimum: date of service, driver's name, driver's signature, Member's name, Member's signature, Vehicle Identification Number (VIN) or other identifying number on file, NET Provider's name, request tracking number, mode of transportation authorized, scheduled arrival time in military time, actual arrival time in military time, actual drop off time in military time, miles driven per odometer, destination and/or Medicaid Provider information, and other notes.

Fixed route transportation is excluded from this requirement. The Contractor shall require NET Providers to make the trip logs available to the Contractor or the Division upon request, within five (5) business days.

J. **Validation Checks**

The Contractor's payment procedures shall ensure that NET Provider claims for reimbursement match authorized trips and that the trips actually occurred. The Contractor shall validate that transportation services paid for under the Contract are properly authorized and rendered. The Contractor shall perform validation checks on at least five percent (5%) NET service requests in a month, both prior to the authorization of the request and after the services are rendered, as specified below.

The Division, at its sole discretion, may require validation checks of trips to specific services.

The Contractor shall conduct pre-transportation validation checks prior to authorizing the request for no fewer than three percent (3%) of the NET services requests received in a month. The Contractor shall contact the Provider and verify that the Member has an appointment for a covered medical service. The Contractor shall not verify the medical necessity of an appointment. If the Contractor verifies with the Provider that no appointment exists, or that the service is not a covered medical service, the Contractor shall record in its computer system the reason for the failed validation check, and the Contractor shall deny the request. If a pre-transportation validation check cannot be completed because the call to the Provider resulted in a busy signal or no answer, the Contractor shall flag the request for a post-transportation validation check, and the attempt at validation shall not be counted toward the three percent (3%) requirement.

The Contractor shall conduct post-transportation validation checks on no fewer than two percent (2%) of the NET services requests received in a month. The Contractor shall contact the Provider and verify that the Member had an appointment for a covered medical service. The Contractor shall verify that the Member received a covered medical service. The Contractor shall not verify the necessity of the transportation or of the medical service, but only that the service occurred. If the Contractor verifies with the Provider that there was no appointment, that the appointment was not kept or that the service was not a covered medical service, the Contractor shall record in its computer system the reason for the failed validation check. If a post-transportation validation check cannot be completed because the call to the Provider resulted in a busy signal or no answer after three (3) attempts, the Contractor shall enter into its system information that will alert the Member Services Call Center staff that any future requests to this specific Provider shall be validated before it can be authorized.

The Contractor shall perform pre-transportation and post-transportation validation checks for three percent (3%) of fixed route transportation requests.

The Contractor shall report all validation check findings to the Division, by NET Provider, via a quarterly Deliverable report.

EXHIBIT F: PERFORMANCE MEASURES

Performance Measure	Source
OBESITY	
1. BMI for adults *Percentage of Members who had an outpatient visit and their body mass index (BMI) documented during the measurement period*	Adult BMI Assessment (ABA) (HEDIS®)
2. BMI, weight assessment for nutrition and physical activity counseling for children and adolescents *Percentage of Members who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year (BMI Percentile Total)*	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *BMI percentile (Total)* (HEDIS®)
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Nutrition (Total)* (HEDIS®)
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Physical Activity (Total)* (HEDIS®)
ASTHMA	
3. Use of appropriate medications for people with asthma *Percentage of Members ages 5-11 and 12-50 who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year*	Use of Appropriate Medications for People with Asthma – Total (ASM) (HEDIS®)
4. Asthma-related ER visits *Percentage reduction in asthma-related ER visits*	N/A – DOM to provide reporting specifications

Performance Measure	Source
5. Avoidable asthma-related re-hospitalizations *Percentage reduction in avoidable asthma-related hospitalizations*	N/A – DOM to provide reporting specifications
WELL-CHILD AND EPSDT	
6. EPSDT Screening *Percentage of children age one(1) or under the age of one (1) who received a Periodic Health Screening Assessment*	Quarterly 416 Report
7. Lead Screening for Children *Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday*	Lead Screening in Children (LSC) (HEDIS®)
8. Childhood Immunizations *Percentage of children 2 years of age who had four (4) diphtheria, tetanus and acellular pertussis (DTaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three(3) H influenza type B (HiB); three(3) hepatitis B (HepB), one(1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); two(2) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two(2) influenza (flu) vaccines by their second birthday*	Childhood Immunization Status – Combo 2 (CIS) (HEDIS®) **Note: The HEDIS measure calculates a rate for each vaccine and nine separate combination rates. This sample HEDIS measure uses Combo 2, which is a combination of vaccines.*
9. Childhood Immunizations *Percent of children age one(1) or under the age of one(1) who have received up-to-date immunizations using the ACIP Recommended Immunization Schedule*	Contractually required

Performance Measure	Source
10. Well-Child Visits in the First 15 Months of Life *Report the number and percentage of Members 12 months old who had a well-child visit during their first 12 months of life*	Well-Child Visits in the First 15 Months of Life (W15) (HEDIS®) Note: Modified to limit to first 12 months of life
11. Screening *Percentage of children age one or under the age of one who received a Periodic Health Screening Assessment*	CMS 416 Report
DIABETES	
12. Nephropathy screening *Percentage of Members with diabetes who received a nephropathy screening test*	Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy (HEDIS®)
13. Cholesterol screening for diabetics *Percentage of Members with diabetes who received a LDL-C screening test*	Comprehensive Diabetes Care (CDC) - LDL Screening (HEDIS®)
14. Cholesterol control for diabetics *Percentage of Members 18 through 75 years of age with diabetes mellitus (Type 1 and Type 2) whose most recent low-density lipoprotein cholesterol (LDL-C) level is less than 100 mg/dL*	Comprehensive Diabetes Care (CDC) - LDL Poor Control (<100 mg/dL) (HEDIS®)
15. Blood sugar poorly controlled in people with diabetes *Percentage of Members with HbA1c results greater than or equal to 9.0 percent*	Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0 percent) (HEDIS®) **Note: Lower rates are desired for this measure.*
16. Blood sugar well-controlled in people with diabetes *Percentage of Members with HbA1c results less than or equal to 8.0 percent*	Comprehensive Diabetes Care (CDC) – HbA1c Good Control (<8.0 percent) (HEDIS®)

Performance Measure	Source
CONGESTIVE HEART FAILURE	
17. Ace inhibitor therapy *Percentage of Members 18 and older on persistent medications (ACE inhibitors) for at least 180 days who received at least one annual monitoring*	Annual Monitoring for Patients on Persistent Medications (MPM) (HEDIS®)
18. Congestive Heart Failure *Percentage decrease in CHF-related hospital readmissions*	N/A – DOM to provide reporting specifications
MATERNAL AND CHILD HEALTH	
19. Pre and post-natal complications *a. Number and percent of deliveries that meet the following criteria, based on gestational weight: low birth weight, very low birth weight, or large for gestational age* *b. Number and percentage of deliveries with prenatal complications (list prenatal complications)*	N/A – DOM to provide reporting requirements
20. Pregnancy Outcome for Members Enrolled Throughout the Pregnancy *For those Members who were enrolled in the first trimester and maintained Enrollment with the same CCO throughout the pregnancy, report the outcome of the pregnancy*	N/A – DOM to provide reporting requirements

Performance Measure	Source
21. Prenatal and Postpartum Care a. *Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit as a Member of the organization in the first trimester or within 42 days of Enrollment in the organization* b. *Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.* c. *Report the number of Members (that received a postpartum visit on or between 21 and 56 days of delivery*	Prenatal and Postpartum Care (PPC) (HEDIS®)
MEMBER SATISFACTION	
22. Member Satisfaction a. *Improve overall rating of health plan (CCO)* b. *Improve percentage of Members reporting they receive needed care*	CAHPS®

Performance Measure	Source
BEHAVIORAL HEALTH	
23. Mental Health Utilization a. *Number and percentage of Members receiving mental health services by service type (e.g., any service inpatient, intensive outpatient/partial hospitalization, outpatient or Emergency Department)* b. *For Members receiving Behavioral Health Services and e enrolled in high-risk Care Management:* ➢ *Treatment plan: number and percentage of Members receiving Behavioral Health Services with a treatment plan (therapy, medications, etc.)* ➢ *Number of emergency department visits for Members receiving Behavioral Health Services*	Mental Health Utilization (MPT) (HEDIS®)
24. Screening for Clinical Depression and Follow-Up Plan a. *Number and percent of Members 18 years and older who were screened for clinical depression using a standardized tool* b. *Number of Members screened who were referred for behavioral health Care Management or Behavioral Health Services (Note: Initial Performance Measure will involve the CCO developing and using a standardized tool)*	Percentage of Members 18 years and older screened for clinical depression using a standardized tool and with documented follow-up, including referral to therapy, inpatient treatment, medication, intensive therapy, etc. CMS Core Adult Measure

Performance Measure	Source
25. Follow-up After Hospitalization for Mental Illness a. *Percentage of Members completing a follow-up appointment after hospitalization for a mental illness within 30 days and/or 7 days of discharge.* b. *CCO to report percentage of Members who did not complete a follow-up appointment within the standards who had a re-admission for mental illness within 15 days of what would have been the 7 day appointment or 45 days from what should have been the 30 day appointment.*	Follow-Up After Hospitalization (FUH) (HEDIS®)

EXHIBIT G: QUALITY MANAGEMENT

The Division will monitor the Quality Management (QM) of the Contractor and retains the right of advance written approval of all QM activities. The Contractor must design its QM program to assure and improve upon the accessibility, availability and quality of care provided for the MississippiCAN Program. The Contractor's QM programs must, at a minimum:

1. Contain a written program description, work plan and program evaluation which meet requirements outlined in the Contract that focus on the areas of importance as identified by the Contract in collaboration with the Division.

2. Be based on and actively evaluate claims data Member demographic information, Member and Provider surveys and other data, as applies, and to use these data for the identification of prevalent medical conditions and barriers to care to be targeted for quality improvement.

3. Continuously evaluate the effectiveness of its activities and make adjustments to the program or to various methodologies or approaches based on these evaluations.

4. Contain written policies and procedures that meet the requirements outlined in the Contract, and monitor internal compliance with these policies and procedures.

5. Maintain a structure and actively ensure that the program is implemented and overseen by professionals with adequate and appropriate experience in QM.

The Contractor must submit to the Division for approval an improvement plan, as determined by the Division, and within time frames established by the Division, to resolve any performance or quality of care deficiencies identified by the Division. The Division must approve the improvement plan. Failure by the Contractor to comply with requirements and improvement actions requested by the Division may result in the application of penalties.

Standard I: The scope of the QM program must be comprehensive in nature, and support the ability of MississippiCAN to improve health outcomes and satisfaction for the Members. This includes, but is not limited to, assessment of access to care, barriers to care, quality of care, Care Management and continuity of services. At a minimum, the Contractor's QM programs, must:

1. Adhere to current Federal, State, and Division rules and regulations.

2. Be developed and implemented by professionals with adequate and appropriate experience in QM.

3. Ensure that all QM activities and initiatives undertaken by the Contractor are chosen based upon claims data, Member demographic information, Member and Provider surveys, Medical Record review data and other data as applies.

4. Contain policies and procedures for all functions of the QM program. The policies and procedures must include ongoing review of the program provided by the Contractor ensuring that all demographic groups and special needs populations are addressed. The Contractor must submit to the Division for approval all policies and procedures prior to initial implementation and upon significant changes.

5. Contain one (1) detailed written program description, which must be approved by the Contractor's Governing Body and the Division prior to implementation and on an ongoing basis as the program description is modified. The program description must address all standards, requirements and objectives established by the Division and describe the goals, objectives and structure of the Contractor's QM program; at a minimum, it must be updated and submitted to the Division annually. The written program description must include:

    a. Standards and mechanisms to monitor Members to receive timely accessibility of primary care, specialty care, in accordance with time frames outlined in Section 7.B, Provider Network Requirements, of this Contract.

    b. Mechanisms for assessment, analysis and reporting of the quality of care provided through the Contractor including, but not limited to:

        i. Primary care;

        ii. Preventive care;

        iii. Acute and/or chronic conditions;

        iv. Care Management and care coordination, including coordination of behavioral health and physical health services;

        v. Continuity of care; and

        vi. Behavioral Health Services.

    c. Assessment of the timely, accurate, complete collection and/or analysis of Member and Provider surveys.

6. The Contractor must submit to the Division for approval the detailed annual work plans and timetables approved by the Contractor's Governing Body prior to implementation, including:

    a. Individual(s) accountable for each task;

    b. Target dates for start dates;

    c. Target dates for completion of all phases of all QM activities;

    d. At least updates on a quarterly basis;

e. Annual submission, which must include prospective QM initiatives for the year;

f. Data collection methods and analysis target dates;

g. Evaluation and reporting of findings to the Division;

h. Implementation of improvement actions where applicable; and

i. Status of each activity.

7. The annual QM Program Evaluation will include:

   a. Studies and activities undertaken;

   b. Rationales and methodologies for activities and studies undertaken;

   c. Results of activities;

   d. Subsequent improvement actions;

   e. An analysis of claims data, Member demographic information, Member and Provider surveys and other data as applies; and

   f. Systematic analysis and re-measurement of barriers to care and the quality of care provided to Members.

8. Include mechanisms and processes that ensure that related and relevant operational components, activities and initiatives from the QM program are communicated and integrated into activities and initiatives undertaken by other departments within the Contractor's organization, delegated Subcontractors, and Care Management programs.

9. Include procedures for informing Providers about the written QM program, and for securing cooperation with the QM program with all PCPs and community-based services.

10. Include procedures for feedback and interpretation of findings from analysis of quality data to PCPs, Care Management staff, community-based services, and Members and their family members.

11. Include mechanisms and processes that allow for the development and implementation of specific improvement actions in response to identified barriers and quality of care concerns within the QM program or the communication of the findings to the Division.

12. Cooperate and coordinate with State initiatives. The Contractor must participate in State health initiatives. This may include, but is not limited to:

    a. Provider outreach and education;

b. Member outreach and education;

c. Quality studies; and

d. Participation in workgroups.

Standard II: The organizational structures of the Contractor must ensure that there is adequate support of the quality management work plan. The Contractor may determine that one (1) Governing Body will oversee all the Quality Management activities.

1. The Governing Body must:

   a. Formally designate an entity, such as the Quality Management Committee (QMC), to have the accountability for and oversight of all aspects of the MississippiCAN Program and evaluation of the effectiveness of the population served.

   b. Regularly receive written reports on the QM program activities that describe actions taken, progress in meeting objectives and improvements made. The Governing Body reviews, on at least an annual basis, the written program description, work plan and program evaluation of the QM program activities.

   c. Document actions taken by the Governing Body in response to findings from QM program activities and supply them to the Division upon request.

   d. Delegate a liaison that is directly accountable to the Division, the Governing Body and the QMC for all QM activities and initiatives.

2. The Quality Management Committee (QMC):

   a. Operates under policies and procedures that describe the role, structure and function of the QMC that:

      i. Demonstrate that the QMC has oversight responsibility and input, including review and approval, for all QM program activities;

      ii. Ensure membership on the QMC and active participation by individuals, representative of the composition of the PCPs; and

      iii. Document actions taken by the QMC in response to findings from QM program activities and supply them to the Division upon request;

   b. Meets at least quarterly, and otherwise as needed; and

   c. Opportunity must be provided for Members to offer suggestions for changes in policies and procedures and how these suggestions will be communicated with the Division.

3. The Contractor must have sufficient material resources, and staff with the education, experience and training to effectively implement the written QM program and related activities. The Contractor must submit to the Division for approval the organizational chart and job descriptions prior to implementation.

Standard III: The QM program must include and implement methodologies that allow for the objective and systematic monitoring, measurement and evaluation of the quality, appropriateness of care and services provided to Members through quality of care studies and related activities, with a focus on identifying and pursuing opportunities for continuous and sustained improvement. The QM program must include professionally developed practice guidelines and standards of care that are written in measurable and accepted professional formats, based on scientific evidence, applicable to PCPs for the delivery of certain types or aspects of health care, and regularly reviewed and updated.

1. The QM program must include clinical and/or quality indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.

2. Practice guidelines and clinical indicators must be measurable and address the health care needs of the populations served by the Contractor. The clinical areas addressed must include, but are not limited to:

    a. Adult preventive care;

    b. Pediatric and Adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

    c. Division-defined clinical areas;

    d. Care Management Related Clinical Outcomes and Performance;

    e. Behavioral health; and

    f. Maternity.

3. The QM program must provide practice guidelines, clinical indicators and Medical Record keeping standards to all Providers and appropriate Subcontractors. The Contractor must also provide this information to Members upon request.

4. The QM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:

    a. Person(s)or body responsible for making the final determinations regarding quality problems; and

b. Types of actions to be taken, such as:

i. Education;

ii. Follow-up monitoring and re-evaluation;

iii. Changes in the Contractor's processes, structures and forms;

iv. Informal counseling;

v. Assessment of the effectiveness of the actions taken; and

vi. Reporting of issues to the Division.

5. The QM program must include methodologies that allow for the identification, tracking, verification and analysis of outpatient quality of care concerns, Member quality of care Complaints and quality of care referrals from other sources. The Contractor must report findings from this analysis of quality of care concerns, Complaints and quality of care referrals to the Division, with a discussion of how these findings will inform the Contractor's quality improvement work plan and how the Contractor will address these concerns. The Contractor will include this information in the QM Program Evaluation.

6. The QM program must contain procedures for the completion of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member satisfaction surveys, and the Contractor must conduct this survey annually. The Contractor must report findings from this survey to the Division, with a discussion of how the findings from the survey will inform the Contractor's quality improvement work plan and effect changes to the program description.

7. The QM program must contain procedures for completion of a Provider satisfaction survey of the PCPs, and must conduct this survey at least annually. The Contractor must report findings from this survey to the Division, with a discussion of how the findings from the survey will inform the Contractor's quality improvement work plan and effect changes to the program description.

Standard IV: The Contractor must develop and implement mechanisms for integration of disease and health management programs that rely on prevention of complications as well as treatment of chronic conditions for Members identified through clinical and financial analysis of claims data provided by the Division, detailed health risk assessments, Member demographic information, and utilization patterns for preventive, secondary and tertiary care.

Standard V: The Contractor must have formal accountability for the QM program. If the Contractor delegates this responsibility, the Contractor must:

1. Have a detailed written description and work plan, approved by the Division, of the delegated activities, the delegate's accountability for these activities and the

frequency of reporting to the Contractor and the Division.

2. Have written procedures approved by the Division for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

3. Document evidence to be submitted to the Division, of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans, quality meeting minutes and regular specified reports.

4. Make available to the Division, and its authorized representatives, any and all records, documents and data detailing its oversight of delegated QM program functions.

5. Ensure that delegated entities make available to the Division, and its authorized representatives, any and all records, documents and data detailing the delegated QM program functions undertaken by the entity of behalf of the Contractor.

6. Ensure the delegated entity adheres to the standards of the current Agreement.

Standard VI: The Contractor must have written policies and procedures for record keeping on all of the Contractor activities.

1. The Contractor must ensure that these records are accurate, timely, and readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for records that promote maintenance of records in a legible, current, detailed, organized and comprehensive manner that permits effective quality review.

2. The Division and/or its authorized Agents (i.e., any individual, corporation, or entity employed, contracted or subcontracted with the Division) must be afforded prompt access to all records whether electronic or paper. All record copies are to be forwarded to the requesting entity within fifteen (15) calendar days of such request and at no expense to the requesting entity. The Division is not required to obtain written approval from a Member before requesting a Member's record from the Contractor or any other agency.

Standard VIII: The Contractor must maintain systems that document implementation of the written QM program descriptions. The Contractor must document that it is monitoring the quality of care across all services, all treatment modalities and all sub-populations according to its written QM program description.

Standard IX: The Contractor must have standards and mechanisms to oversee the PCPs and report findings to the Division.

1. The Contractor must oversee that the PCPs are adhering to:

    a. Federal, State and Division rules and regulations;

b. PCP requirements;

c. Members' rights; and

d. Clinical and preventive guidelines of the program.

2. The Contractor must submit to the Division for approval the initial versions and any revisions made to the following documents that relate to the QM program:

   a. Table of Organization including job descriptions;

   b. Employee tools to include scripts, algorithms and criteria;

   c. Program Descriptions;

   d. Work Plans;

   e. Program Evaluations;

   f. Performance Improvement Projects;

   g. Focused Studies; and

   h. Other documents related to the QM program, as designated by the Division.

3. The Division may request additional information from the Contractor to assist in the determination of Contract compliance. To the extent possible, the Division shall provide reasonable advance notice of such reports. These may include:

   a. Committee Meeting Minutes;

   b. Work Plan Updates;

   c. Contractor Documentation;

   d. Ad Hoc Reports and Information;

   e. Contractor Demonstrations; and

   f. Access to materials and the ability to observe during on-site evaluations.

EXHIBIT H: REPORTING REQUIREMENTS

Contractor Report	Frequency	Time Frame
Monthly Management Report		
Care Coordination	Monthly	Fifth (5th) business day of second month following reporting period
Claims Processing Summary by Claim Type		
Member Enrollment Statistics and Trends		
Member Services Call Center Statistics		
NET Operations		
Provider Network		
Prior Authorization and Denials		
Utilization Statistics and Trends		
Enrollment		
Enrollment Reports	Monthly	Fifteenth (15th) calendar day of the month after the Member Listing Report is issued
New Member Identification Cards	Monthly	Fifth (5th) business day of the month after the close of the month
Returned Member Identification Cards	Monthly	Fifth (5th) business day of the month after the close of the month
Complaints, Grievances, and Appeals		
Detailed Log of Grievances and Appeals	Monthly	Fifteenth (15th) business day after the close of the month
Summary of Complaints, Grievances, and Appeals	Monthly	Fifteenth (15th) business day after the close of the month
Provider Network		
Accessibility and Availability Review	Quarterly and Annually	Fifteenth (15th) business day after the close of the quarter April first (1st)
Contracted Hospitals	Quarterly	Fifteenth (15th) business day after the close of the quarter
Network Geographic Access Assessment (GeoAccess)	Quarterly	Fifteenth (15th) business day after the close of the quarter

Contractor Report	Frequency	Time Frame
Provider Services Call Center Audit	Quarterly	Fifteenth (15th) business day after the close of the quarter
Provider Services Call Center Trainings	Quarterly	Fifteenth (15th) business day after the close of the quarter
Provider Services Reports,	Quarterly	Fifteenth (15th) business day after the close of the quarter
Care Management		
Care Management Reports	Monthly	Fifth (5th) business day of second month following reporting period
EPSDT Reports	Quarterly and Annually	Fifteenth (15th) business day after the close of the quarter Fifteenth (15th) business day of February for prior reporting year
PHRM/ISS Report	Quarterly	Fifteenth (15th) business day after the close of the quarter
Health Education and Marketing		
Health Education and Prevention Work Plan	Annually	January fifteenth (15th) for the current calendar year
Health Education and Prevention Work Plan Updates	Quarterly	Fifteenth (15th) business day after the close of the quarter
Log of Completed Marketing Activities	Quarterly	Fifteenth (15th) business day after the close of the quarter
Marketing Complaint Tracking Log	Quarterly	Fifteenth (15th) business day after the close of the quarter
Marketing Work Plan	Annually	January fifteenth (15th) for the current calendar year
Member Health Education Materials (e.g., Member newsletters)	Annually	January fifteenth (15th) for the current calendar year
Member Information Packet	Annually	January fifteenth (15th) for the current calendar year

Contractor Report	Frequency	Time Frame
Member Services Call Center Audit	Quarterly	Fifteenth (15th) business day after the close of the quarter
Member Services Call Center Trainings	Quarterly	Fifteenth (15th) business day after the close of the quarter
Financial and Administrative		
Contractor Licensures	Annually	April first (1st)
Data Necessary for Drug Rebate Collection	Weekly	As specified by the Division
Department of Insurance (DOI) Filings	Quarterly and Annually	As specified by DOI
Disenrollment Survey Results	Quarterly	Fifteenth (15th) business day after the close of the quarter
Encounter Data	Weekly	As specified by the Division
Encounter Data Completeness Plan	Annually	January fifteenth (15th) for the current calendar year
Fraud and Abuse Compliance Plan	Annually	January 15th fifteenth (15th) for the current calendar year
Foster Care Children	As specified by DHS and the Division	As specified by DHS Fifth (5th) business day of second month following reporting period to the Division
Medical Loss Ratio	Annually	June first (1st)
NET Inspections and Validation Check Report	Quarterly	Fifteenth (15th) business day after the close of the quarter
Provider-Preventable Conditions	Quarterly	Fifteenth (15th) business day after the close of the quarter
Small and Minority Business Reporting	Annually	Contract signature date anniversary
Suspected Fraud and Abuse Cases	Quarterly	Fifteenth (15th) business day after the close of the quarter
Third Party Liability	Monthly	Thirtieth (30th) of every month

Contractor Report	Frequency	Time Frame
Quality Management (QM)		
CAHPS® Results	Annually	September thirtieth (30th)
HEDIS® Results	Annually	July thirty-first (31st)
Internal QM Audit	Semi-Annually	April first (1st) following the October thru March reporting period October thirty-first (31st) following the April thru September reporting period
Patient-Centered Medical Home	As specified by the Division	As specified by the Division
Performance Measure Results	Annually	March first (1st) for the current calendar year
Performance Measure Result Updates	Quarterly	Fifteenth (15th) business day after the close of the quarter
PIP Updates	Quarterly	Fifth (5th) business day of the month after the close of the quarter
PIP Results	Annually	April first (1st) following the reporting year
Provider Satisfaction Survey Questions and Methodology	Annually	March first (1st) for the current calendar year
Provider Satisfaction Survey Results	Annually	At least ninety (90) calendar days following the completion of the survey and no later than December first (1st) for the current calendar year
QM Program Description	Annually	April first (1st)for the current calendar year
QM Program Evaluation	Annually	April first (1st) following the reporting calendar year
QM Work Plan	Annually	April first (1st) for the current calendar year
QM Work Plan Updates	Quarterly	Fifteenth (15th) business day after the close of the quarter
Utilization Management Program Description (specific to the MississippiCAN Program)	Annually	April first (1st) for the current calendar year