

CONTRACT BETWEEN THE DIVISION OF MEDICAID
IN THE OFFICE OF THE GOVERNOR
STATE OF MISSISSIPPI
AND
CONTRACTOR
FOR ADMINISTRATION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM

Division of Medicaid
Office of the Governor
State of Mississippi
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201-1399

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**CONTRACT BETWEEN
THE DIVISION OF MEDICAID
IN THE OFFICE OF THE GOVERNOR
STATE OF MISSISSIPPI
AND
[Insert Contractor Name]**

This Contract is made and entered into this 1st day of February, 2019 by and between the Division of Medicaid in the Office of the Governor, an administrative agency of the State of Mississippi, with a principal place of business located at 550 High Street in the City of Jackson, County of Hinds, State of Mississippi (hereinafter "Division"), and [Insert Contractor Name], 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 [Insert Contractor Address] (hereinafter "Contractor").

WHEREAS, the Division is charged with the administration of the **Child Health Plan** for the Children's Health Insurance Program (CHIP) in accordance with the requirements of Title XXI of the Social Security Act of 1935, as amended, (the "Act") and Miss. Code Ann. § 41-86-1, *et. seq.*, and §43-13-101 *et. seq.*;

WHEREAS, the Contractor is an entity eligible to enter into a full risk capitated contract in accordance with Section 1903(m) of the Act 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 Mississippi Insurance Department of the State of Mississippi pursuant to Miss. Code Ann. §83-41-305; and

WHEREAS, the Division desires to contract with a Coordinated Care Organization (Contractor) to obtain services for the benefit of a separate child health program in accordance with Section 2101(a)(1) of the Act, and 42 C.F.R. § 457.70 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 covenants contained herein, and subject to the terms and conditions hereinafter stated, it is hereby understood and agreed by the parties hereto as follows:

SECTION 1 – GENERAL PROVISIONS

A. Term

The term of this Contract shall commence on February 1, 2019, and shall expire on January 31, 2022, unless this Contract is terminated pursuant to Section 15, Non-Compliance and Termination. The Division has under the same terms and conditions as the existing Contract, the 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 unless otherwise stated.

This Contract between the Division and the Contractor consists of 1) this Contract and any amendments thereto; 2) the Mississippi CHIP RFQ and any amendments thereto; 3) the Contractor's Qualification submitted in response to the RFQ 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 Contractor's Qualification and its attachments, the RFQ, and written questions and answers. In the event that an issue is addressed in one 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 RFQ or the Contractor's Qualification. In all other matters not affected by the written clarification, if any, the order of priority outlined above shall govern.

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

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 must be approved by the Centers for Medicare and Medicaid Services (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:

The Contractor: Chief Executive Officer

The Division: Executive Director

C. State and Federal Law

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, Title XXI of the Act, 42 C.F.R. § 457 Subpart A, and 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 CMS.

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.

The Contractor expressly agrees to all of the provisions and requirements as set forth in the State Health Plan approved by the State of Mississippi and by the Secretary of the United States Department of Health and Human Services, pursuant to the Title XXI of the Act, and understands those provisions and requirements are also incumbent on the Contractor.

See also Section 4.3.6, Applicable Law, and section 4.1, General, of the Mississippi CHIP RFQ for additional requirements.

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

PROCUREMENT REGULATIONS The Contract shall be governed by the applicable provisions of the Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations, a copy of which is available at 501 North West Street, Suite 701E, Jackson, Mississippi 39201 for inspection, or downloadable at <http://www.DFA.ms.gov>.

D. Representatives for the Division and the Contractor

The Executive Administrator of the Division shall serve as the Contract Officer, representing the Executive Director of the Division, with full decision-making authority. All statewide policy decisions or Contract interpretation will be made through the Executive Administrator of the Division. The Executive Administrator 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 CHIP policy. When interpretations are required, the Contractor will submit written requests to the Division.

The Contractor's Chief Executive Officer or a comparable representative shall serve as Contract Officer for the Contractor, with full decision-making authority for the Contractor, and will be required to be physically located in the State of Mississippi.

Each Contract Officer reserves the right to delegate such duties as may be appropriate to others in the Officer's employment or under the Officer's supervision.

E. Notices

Whenever, under this Contract or associated RFQ, one party is required to give notice to the other, except for purposes of Notice of Termination under Section 15.J, 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 email, 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 with a copy and delivery to the Deputy Director.

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:

[Insert Contractor Name & Address]

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 CHIP providing the types of services described in this Contract;
2. The Contractor is licensed in the State of Mississippi by the Mississippi Insurance Department as a health maintenance organization; or is in the process of obtaining license in Mississippi to be effective prior to the Enrollment of Members;
3. All information and statements contained in the CHIP Contract Qualification and responses to additional letter inquiries submitted by the Contractor to the Division are true and correct as of the date of this Contract;
4. A copy of the Contractor's Qualification as approved by the Division is on file in the Contractor's office in Mississippi and any revisions to the Qualification 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 shall comply with requirements under 42 C.F.R. § 457.955 as applicable to managed care organizations serving CHIP; and
8. All covered services provided by the Contractor will meet the quality management (QM) standards of the Division, and will be furnished to Members as promptly as necessary to meet each individual's needs.

In compliance with Section 2103(f) of the Act, the Contractor shall provide assurances, as required by Section 1932(b) of the Act, to State and Federal officials (CMS) 1) that within its service area, it has the capacity to serve its expected enrollment, that it maintains an adequate number, mix, and geographic distribution of Providers, that it offers an appropriate range of services and access to preventative and primary care services for the expected enrolled population, and 2) that it will comply with certain maternity and mental health requirements contained in Title XXVII of the Public Health Service Act as applicable to CHIP.

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 Mississippi Insurance Department 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 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;

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

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;

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;

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

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 Qualification in accordance with the State's procurement process;

- b. Annually, including upon execution, renewal, or extension of the Contract with the State; and
- c. Within thirty-five (35) calendar days after any change in ownership of the Contractor.

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. As described in 42 C.F.R. § 438.808, FFP is also not available for any amounts paid to Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

- a. Contractor is controlled by a sanctioned individual;
- b. Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act; or
- c. Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following: (a) any individual or entity excluded from participation in Federal health care programs. (b) Any entity that would provide those services through an excluded individual or entity.

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 (HHS) or the Division, full and complete information about:

- a. The ownership of any Subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during the twelve (12)-month period ending on the date of the request; and
- b. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any Subcontractor, during the five (5)-year period ending on the date of the request.

Any disclosing entity that is subject to periodic survey and certification of its compliance with CHIP 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 XIX 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 Network Provider entity or who is an agent or managing employee of the Provider (as defined by 42 C.F.R. § 455.101) and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XIX 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. § 1002.4.

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. § 1002.4. 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 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 C.F.R. § 455.104 and 42 C.F.R. § 455.106 also require disclosure of all entities with which a CHIP 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 CHIP coordinated care business in Mississippi or other states. This includes, but is not limited to, sale of existing business to other entities or a complete exit from the State of Mississippi to another state or jurisdiction.

1. Change of Ownership

A change of ownership of the Contractor includes, but is not limited to inter vivo gifts, purchases, transfers, lease arrangements, cash 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 Insurance Department 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.

2. Prohibited Affiliations

Contractor shall not knowingly have a prohibited affiliation with the following:

- a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and
- b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in subparagraph 3.1 of this Section.

Prohibited affiliations are defined as follows:

- a. A director, officer, or partner of Contractor;
- b. A subcontractor of Contractor as governed by 42 C.F.R. § 438.230;
- c. A person with beneficial ownership of 5 percent or more of the Contractor's equity; and,
- d. A network Provider or person with an employment, consulting, or other arrangement with Contractor for the provision of items and services that are significant and material to Contractor's obligations under this Contract.
- e. Contractor may not have a relationship with an individual or entity that is excluded from participation in any Federal healthcare program under Section 1128 or 1128A of the Act.

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

- a. Must notify the HHS Secretary of Contractor's non-compliance;
- b. May continue this Contract with Contractor unless the Secretary directs otherwise; or
- c. May not renew or otherwise extend this Contract unless the Secretary provides to the State of Mississippi and to Congress a written statement describing compelling reasons that exist for renewing or extending this Contract despite the prohibited affiliations.
- d. Nothing in this section must be construed to limit or otherwise affect other remedies available to the United States under Sections 1128, 1128A, or 1128B of the Act.
- e. Any action by the Secretary described herein is taken in consultation with the Inspector General.

J. Responsiveness to the 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 oral requests for assistance no later than one (1) business day from receipt of the request from the Division, and the request shall be completed by Contractor to the satisfaction of the Division within five (5) business days from the date of receipt unless another time frame is specified by the Division. Requests by Contractor for extension of the time frame may be granted by the Division in its discretion. If the request is urgent, Contractor shall immediately, without unreasonable delay, acknowledge the Division's urgent requests for assistance and shall give such requests priority. Urgent requests shall be completed by Contractor to the satisfaction of the Division within the time frame specified by the Division. If no timeframe is specified, urgent requests shall be completed within five (5) business days from the date of receipt. Such urgent requests include, but are not limited to, State Issues, Liquidated Damages, 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. Executive requests, program requests, and Investigated Grievances shall be considered urgent.

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

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

The Contractor may be subject to Liquidated Damages or other available remedies in accordance with Section 15, Non-Compliance and Termination, of this Contract if the Contractor is in violation of this section.

K. The Division's Policies and Procedures

The Contractor shall comply with all applicable policies and procedures of the Division, specifically including without limitation all policies and procedures applicable solely to CHIP, which are also covered by the Children's Health Insurance Program Reauthorization Act (CHIPRA) and State Health Plan, all of which are hereby incorporated into this Contract by reference and form as an integral part of this Contract. In instances of disagreement, the interpretation of policy is under the Division's discretion. In no instance may the limitations or exclusions imposed by the Contractor with respect to covered services 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 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:

1. Information must be consistent with the provisions of 42 C.F.R. § 438.10;
2. Information must be provided to potential Members before and during Enrollment; and
3. Information must be provided to Members within ninety (90) calendar days after adopting the policy with respect to any service and at least thirty (30) calendar 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, RFQ, the Contractor's Qualification, 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 designated CEO (Contract Officer), with decision-making authority, to oversee the day-to-day business activities conducted pursuant to this Contract located in Mississippi. The Mississippi CEO 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 must be able to make decisions about CHIP activities.
2. Chief Operating Officer: A designated Chief Operating Officer located in Mississippi to administer 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. The Medical Director will also serve as a liaison between the Contractor and Providers; be available to the Contractor's staff for consultation on referrals, denials, Complaints, Grievances, and Appeals; review potential quality of care problems, and participate in the development and implementation of corrective action plans.
5. Chief Information Officer: A professional who will oversee information technology and systems to support the 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 professional located in Mississippi to be responsible for oversight of Provider Services and network development.
2. Member Services Manager: A professional located in Mississippi to be responsible for oversight of Member services functions.
3. Quality Management Director: A health care practitioner responsible for overseeing QM and improvement activities.
4. Utilization Management (UM) Coordinator: A health care practitioner responsible for UM functions.
5. Grievance and Appeals Coordinator: A professional responsible for the processing and resolution of all Member Grievances and Appeals and Provider Complaints, Grievances, and Appeals.
6. Claims Administrator: A professional responsible for overseeing claims administration.
7. Other key personnel as identified by the Contractor.

The Division must approve key personnel required to be located in Mississippi prior to assignment. The Division reserves the right to approve additional key positions as needed. 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 in accordance with Section 15.E, Liquidated Damages. The Contractor must submit to the Division for prior approval the proposed replacement for key positions at least fifteen (15) calendar days before hire. If the position is filled without the Division approval, the Division may impose penalties in accordance with Section 15.E, Liquidated Damages, 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. The Contractor shall report these changes 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 Network Providers, and all Out-

of-network Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations;

3. Designated staff to be responsible for Marketing 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 CHIP Members' Care Management needs at all times; and
6. Designee(s) who can respond to issues involving systems and reporting, encounter data, Appeals, quality assessment, Member services, Provider services, Well-Baby and Well-Child Care assessments and immunization services, pharmacy management, medical management, and Care Management.

M. Base of Operations

The Contractor shall not be located outside of the United States.

The Contractor shall have an Administrative Office within fifteen (15) miles of the Division'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 the Division premises, comply with site rules and regulations.

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

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 and commitment to provide and deliver quality health care across a variety of cultures.

The Contractor must promote access and delivery of services, in a culturally competent manner to all Medicaid Members including, but not limited, to those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of race, color, religion, national origin, sex, sexual orientation, gender, gender identity or disability. The Contractor must ensure that Members have access to covered services that are delivered in a manner that meets their unique needs.

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. One of these Agents may include but is not limited to the Fiscal Agent that will process encounter data submitted by Contractors to the Division, 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 performing work under this Contract. 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 the 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, specifically on the first business day following the Contract signing, and annually thereafter.

Q. Readiness Reviews

The Contractor shall comply with all requirements related to the assessment of the Contractor's performance prior to implementation. The Division may, at its discretion, complete readiness reviews of the Contractor prior to implementation of CHIP expansions and Contract renewals, which must be completed three (3) months prior to the operational go-live. 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.

SECTION 2 – DEFINITIONS

A. Definitions

1. **Abuse:** Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, the Contractor, 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.
2. **Actuary:** An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.
3. **Administrative Service:** Administrative Service means the performance of services or functions, other than the direct delivery of Covered Services, necessary for the management of the delivery of and payment for Covered Services, including but not limited to network utilization, clinical or quality management, service authorization, claims processing, management information systems operation, reporting, and infrastructure development for, preparation of, and delivery of, all required Deliverables under the Contract.
4. **Advance Beneficiary Notification (ABN):** A notice to the Member indicating that an item(s) 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).
5. **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Division; the failure of the Contractor to act within the timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; for residents in a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.
6. **Agent:** An authorized entity that acts on behalf of the Division.
7. **Allowable Charge:** The lesser of the submitted charge or the amount established by

the Contractor, as provided through Provider Network contracts or based on analysis of Provider charges, as the maximum amount for all such Provider services covered under the terms of this Contract.

8. **Appeal:** A request for review by the Contractor of an Adverse Benefit Determination related to a Member or Provider review by the Contractor of an Adverse Benefit Determination. In the case of a Member, the Adverse Benefit Determination may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member). In the case of a Provider, the Adverse Benefit Determination may include, but is not limited to, delay or non-payment for covered services
9. **Auto Enrollment:** The process by which Members who have not voluntarily selected a CHIP Contractor are assigned to a CHIP Contractor.
10. **Behavioral Health/Substance Use Disorder:** Mental health and/or drug and alcohol abuse treatment services provided by the county mental health/Intellectually Delayed/Developmentally Delayed programs the single county authority administrators, or other appropriately licensed health care practitioners.
11. **Benchmark Plan:** Medicaid Benefits Coverage, with exceptions as outlined by CHIPRA and 42 C.F.R §457.
12. **Benefit Period:** A period of one (1) calendar year commencing each July 1.
13. **Capitation Payments:** Actuarially determined, per Member per month rates paid to the Contractor for the provision of all covered services to enrolled Members.
14. **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.
15. **Case Identification Number:** With respect to the Member, includes Immediate Family Members and individuals living with the Member.
16. **Child:** For purposes of this Contract, an individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Also referred to as Member.
17. **CHIP:** The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.
18. **Closed Panel:** Providers who are no longer accepting new Members for the Contractor.
19. **Complaint:** An expression of dissatisfaction, regardless of whether identified as a

“Complaint”, received by any employee of the Contractor orally or in writing that is of a less serious or formal nature that is resolved within one (1) calendar day of receipt. A Complaint not resolved within one (1) calendar day of receipt shall be treated as a Grievance.

20. **Contractor:** An entity eligible to enter a full risk capitated contract in accordance with Section 1903(m) of the Social Security Act and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. § 438.2.
21. **Coordinated Care Organization (CCO):** An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP.
22. **Co-Payment:** The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on the health care service being provided.
23. **Cost Sharing:** In accordance with 42 C.F.R. § 457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.
24. **Creditable Coverage:** Prior health insurance coverage as defined under Section 2701(c) of the Public Health Service Act (42 U.S.C. § 300gg(c)). Creditable Coverage includes coverage under group or individual health plans or health insurance, Medicare, Medicaid, other governmental plans and state health benefit risk pools.
25. **Credibility Adjustment:** An adjustment to the Medical Loss Ratio (MLR) provided by the Contractor in accordance with 42 C.F.R. § 438.8 to account for a difference between the actual and target MLR that may be due to random statistical variation.
26. **Custodial Nursing Home:** Residential designation after a Member has exhausted skilled services. However, the Member continues to have the need for non-skilled, personal care, including assistance with activities of daily living such as bathing, dressing, eating, toileting, ambulating and transferring in a nursing facility.
27. **Deliverables:** Those documents, records, and reports required to be furnished to the Division for review and/or approval pursuant to the terms of the RFQ and this Contract.
28. **Direct Paid Claims:** Claims payments before ceded Reinsurance and excluding assumed Reinsurance except as otherwise provided in Exhibit D, Medical Loss Ratio Requirements, of this Contract.
29. **Disenrollment:** Adverse Benefit Determination 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.

30. **Division:** Division of Medicaid , Office of the Governor, State of Mississippi.
31. **Division of Medicaid (Division) Investigated Grievance:** A written Member or Provider Grievance to the Executive Administrator of the Division (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 Grievance is valid even if the disposition of the Complaint is not resolved in favor of the complaining party. To be considered valid, these grievances must consist of Complaints or disputes expressing dissatisfaction with any aspect of the operations, activities, or behavior of the Contractor, or its Providers, that is in violation of the terms of this Contract and/or State or Federal law and that has the potential to cause material harm to the complainant regardless of whether remedial action is requested.
32. **Emergency Medical Condition:** In accordance with Section 1932(b) of the Act, and 42 C.F.R. § 457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.
33. **Emergency Services:** Inpatient or outpatient health care services inclusive of dialysis services, that are furnished by any Provider qualified to furnish such services under CHIP and needed to evaluate, treat, or stabilize an Emergency Medical Condition. This in accordance with 42 C.F.R. § 438.114.
34. **Emergency Transportation:** Ambulance services for emergencies.
35. **Enrollment:** Benefit Determination taken by the Division to add a Member's name to the Contractor's monthly Member Listing report following the receipt and approval by the Division of an Enrollment application from an eligible Member who selects a Contractor or upon Auto Enrollment of a Member to a Contractor.
36. **Expedited Resolution:** An expedited review by the Contractor of a Contractor Adverse Benefit Determination within three (3) calendar days after the Contractor receives the request, which may extended by up to fourteen (14) days.
37. **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.
38. **Federally Qualified Health Centers (FQHC):** All organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and

FQHC Look-Alikes. FQHCs 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.

39. **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 Medicaid Members based on the payment methods set forth in the Medicaid State Plan and the applicable policies and procedures of the Division.
40. **Fraud:** 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.
41. **Grievance:** An expression of dissatisfaction, regardless of whether identified as a "Grievance", received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.
42. **Immediate Family Member:** With respect to the Member, may include the following: i) the husband or wife of the Member; ii) the biological or adoptive parent, Child, or sibling of the Member; iii) the stepparent, stepchild, stepbrother, or stepsister of the Member; iv) the father, mother, daughter, son, brother, or sister-in-law of the Member; v) the grandparent or grandchild of the Member; and vi) the spouse of a grandparent or grandchild of the Member.
43. **Indian:** An individual, defined at title 25 of the U.S.C. § 1603(c), 1603(f), 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. § 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health Providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U)) or through referral under Contract Health Services.
44. **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 Mississippi Insurance Department pursuant to Miss. Code Ann. §83-41-329.
45. **Liquidated Damages:** Reasonable monetary damages fixed by the parties in advance for the Contractor's failure to meet the requirements of this Contract and/or all documents incorporated herein because calculating the actual damages resulting from

such failures are uncertain, extremely difficult and/or impractical to ascertain and determine.

46. **Marketing:** Any communication from the Contractor to a Member who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the Member to enroll in that particular Contractor or either to not enroll in or to disenroll from another Contractor.
47. **Material Adjustment:** An adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.
48. **Medical Home:** A health care setting that facilitates partnerships between individual Members, their Primary Care Providers, and when appropriate, the Member's family to provide comprehensive primary care.
49. **Medical Loss Ratio (MLR):** The proportion of premium revenues spent on clinical services and quality improvement by the Contractor as calculated in accordance with the requirements of 42 C.F.R. §438.8.
50. **Medical Loss Ratio Reporting (MLR) Year:** A twelve (12) month period consistent with the Rating Period (e.g., July 1 through June 30) during which benefits and services are provided to Members through contract with the Division.
51. **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 Network Providers or Out-of-network Providers.
52. **Medically Necessary Services:** 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 Member's condition, illness, or injury;
 - b. In accordance with the standards of good medical practice consistent with the individual Member'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 Member'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 Member's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically necessary services are also the most appropriate services that help achieve age-appropriate growth and development and will allow a Member to attain, maintain, or regain capacity.

- 53. **Member:** An individual who meets all of the eligibility requirements for CHIP, enrolls in a Contractor under CHIP, and receives health benefits coverage through CHIP.
- 54. **Member Encounter Data:** The information relating to the receipt of any item(s) or service(s) by a Member under this Contract and is subject to the requirements of 42 C.F.R. §§438.242 and 438.818.
- 55. **Member Encounter Data Record:** A single electronic record of Claims for any item(s) or service(s) adjudicated by the Contractor, or by its Subcontractors, to Providers that have provided services to Members that is subject to the requirements of 42 C.F.R. §§438.242 and 438.818. An Encounter Record captures and reports information about each specific service provided each time a Member visits a Provider, regardless of the contractual relationship between the Contractor and Provider or Subcontractor and Provider.
- 56. **Member Months:** The number of months a Member or group of Members is covered by Contractor during the Medical Loss Ratio Reporting (MLR) Year.
- 57. **Non-claims Costs:** Those expenses for administrative services that are not: Incurred claims (as defined in paragraph (e)(2) of 42 C.F.R. §438.8); expenditures on activities that improve health care quality (as defined in paragraph (e)(3) of 42 C.F.R. §438.8); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of 42 C.F.R. §438.8).
- 58. **Ongoing Course of Treatment:** A Member is considered to be receiving an Ongoing Course of Treatment from a Provider under the following circumstances: (i) 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; or (ii) any Child with a previously scheduled appointment, including an appointment for Well-Baby and Well-Child Care Services.
- 59. **Open Panel:** Providers who are accepting new CHIP Members as patients from

the Contractor.

60. **Out-of-network Provider:** A health care Provider who has not been credentialed by and does not have a signed Provider agreement with the Contractor.
61. **Out-of-Pocket Maximum:** The aggregate amount of Cost Sharing (e.g., deductibles, co-insurance, and Co-Payments) incurred by all enrolled Children in a single family in a Benefit Period. Once the Out-of-Pocket Maximum has been met, covered expenses are paid at one hundred percent (100%) of the Allowable Charge for the remainder of the Benefit Period.
62. **Panel:** Listing and number of Members that Network Providers have agreed to provide services for in accordance with this Contract.
63. **Partial Credibility:** A standard for which the experience of a Contractor is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. A Contractor that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR.
64. **Performance Improvement Project:** A process or project to assess and improve processes, thereby improving outcomes of health care.
65. **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.
66. **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.
67. **Preferred Drug List (PDL):** A medication list recommended to the Division by the Pharmacy & Therapeutics Committee and approved by the Executive Director of the Division. 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 Division's PDL.
68. **Premium Revenue:** Includes the following for the MLR Reporting Year:
 - a. Capitation Payments, developed in accordance with 42 C.F.R. § 438.4, to the Contractor, for all Members under a risk contract approved under 42 C.F.R. § 438.3(a) and 457.1201, excluding payments made under to 42 C.F.R. § 438.6(d).
 - b. State-developed one time payments, for specific life events of Members.
 - c. Other payments to the Contractor approved under 42 C.F.R. § 438.6(b)(3).

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

e. All changes to unearned premium reserves.

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

- 69. 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 CHIP, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Family and General Practitioner, Nurse Practitioners (who meet requirements of Section 4.B, Choice of a Health Care Professional), Physician Assistants, specialists who perform primary care functions upon request, and other Providers approved by the Division..
70. **Prior Authorization:** A determination to approve a Provider's request, pursuant to services covered in CHIP, 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.
71. **Provider:** Any individual or entity that is engaged in the delivery of services, or ordering or referring for those health services, and is legally authorized to do so by the State in which it delivers the services.
72. **Provider Network:** The panel of health service Providers with which the Contractor contracts for the provision of covered services to Members and Out-of-network Providers administering services to Members.
73. **Provider-Preventable Conditions:** A condition that meets the definition of a "healthcare-acquired condition" or an "other Provider-preventable condition" as defined by 42 C.F.R. §447.26.
74. **Rate Cell:** A set of mutually exclusive categories of Members that is defined by one or more characteristics for the purpose of determining the capitation rate and making a Capitation Payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each Member should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under this Contract.
75. **Rating Period:** A period of twelve (12) months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 C.F.R. Section 438.7(a). The Rating Period shall be July 1 to June 30 consistent with the State fiscal year.
76. **Redetermination Date:** The date when CHIP eligibility requirements are reviewed to ensure the Member is eligible to continue receiving benefits.

77. **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.
78. **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.
79. **Retroactive Eligibility Review:** A review that is conducted after services are provided to a Member and the Member is retroactively determined to be eligible for Medicaid. The Division provides retroactive Medicaid eligibility for a Member that was not eligible for Medicaid benefits at the time of hospitalization.
80. **Retrospective Inpatient Hospital Review:** A review that is conducted for inpatient hospital services after the services are provided to a Member. Retrospective Inpatient Hospital Reviews include those admissions where the Member was admitted and discharged and certification was not obtained while the Member was hospitalized.
81. **Retrospective Review:** A review that is conducted after services are provided to a Member.
82. **Rural Health Clinics:** The Rural Health Clinics (RHCs) program is intended to increase primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, private, or non-profit. RHCs receive enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must be located in rural, underserved areas and must use midlevel practitioners.
83. **State Health Plan:** State of Mississippi's plan submitted to HHS for the administration of CHIP.
84. **State Issue:** A verbal or written point of discussion or expression of dissatisfaction received from a Member, Member's representative or Providers that are not in compliance with the goals of the Mississippi CHIP program. These may include benefits, services, reimbursement, enrollment (Member or Provider) and any other issue.
85. **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. The Division must approve Subcontracts in writing prior to the start date of the agreement.
86. **Subcontractor:** An entity with which the Contractor enters into an agreement to provide contractually required services.

87. **Third Party Liability/Resource:** Any resource available to a Member for the payment of medical expenses associated with the provision of covered services including but not limited to, insurers and workers' compensation plans.
88. **Transitional Care Management:** A type of Care Management program to support Members' transition of care when discharged from an institutional clinic or inpatient setting.
89. **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.
90. **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.
91. **Well-Baby and Well-Child Care Services:** Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by the Division in the State Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

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. CHIP – Children's Health Insurance Program
8. CLIA – Clinical Laboratory Improvement Amendments
9. CMS – Centers for Medicare and Medicaid Services
10. COB – Coordination of Benefits
11. CPS – Child Protection Services
12. CST – Central Standard Time

13. EDI – Electronic Data Interchange
14. EPA – United States Environmental Protection Agency
15. EQR – External Quality Review
16. EQRO – External Quality Review Organization
17. FFP – Federal Financial Participation
18. FQHC – Federally Qualified Health Center
19. GAAP – Generally Accepted Accounting Principles
20. GAO – General Accounting Office
21. HEDIS® – Healthcare Effectiveness Data and Information Set
22. HHS – United States Department of Health and Human Services
23. HIPAA – Health Insurance Portability and Accountability Act of 1996
24. I/T/U – Indian Tribe, Tribal Organization, or Urban Indian Organization
25. LTSS – Long Term Support Services
26. MCO – Managed Care Organization
27. MDFA - Mississippi Department of Finance and Administration
28. MES – Medicaid Enterprise System
29. MLR – Medical Loss Ratio
30. MMIS – Medicaid Management Information System
31. MS HIN – Mississippi Health Information Network
32. MSDH – Mississippi State Department of Health
33. NCQA – National Committee for Quality Assurance
34. NPI – National Provider Identifier
35. OIG – Office of Inspector General
36. PAHP – Prepaid Ambulatory Health Plan
37. PBM – Pharmacy Benefits Manager

- 38. PCP – Primary Care Provider
- 39. PDL – Preferred Drug List
- 40. PHI – Protected Health Information
- 41. PI – Program Integrity
- 42. PIHP – Prepaid Inpatient Health Plans
- 43. PII – Personal Identification Information
- 44. PIP – Performance Improvement Project
- 45. PRTF – Psychiatric Residential Treatment Facilities
- 46. QI – Quality Improvement
- 47. QM – Quality Management
- 48. QMC – Quality Management Committee
- 49. RHC – Rural Health Clinic
- 50. TPL – Third Party Liability and Recovery
- 51. TTY/TTD – Text Telephones/Telecommunications Device for the Deaf
- 52. UM – Utilization Management

SECTION 3 – MEMBER ELIGIBILITY

A. Eligible Populations for CHIP

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

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

Table 1 specifies populations that must enroll in CHIP. The Division will enroll eligible Members within these categories into one of two Contractors participating in CHIP, and Members will have the option to disenroll once within ninety (90) days of initial Enrollment. Members that disenroll and do not choose another Contractor under CHIP may enroll in the Division's Medicaid program if they meet Medicaid eligibility requirements or pursue private insurance independently from the Division.

Table 1. Populations Who Are Eligible for CHIP

Populations	Income Level
Birth to Age One (1) Year	194% FPL to 209% FPL
Ages One (1) to Six (6) Years	133% FPL to 209% FPL
Age Six (6) to Nineteen (19) Years	133% FPL to 209% FPL

B. 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. The Division will work to review and approve within forty-five (45) calendar days.

SECTION 4 – ENROLLMENT AND DISENROLLMENT

The Division or its Agent shall send written notification to the Member to inform the Member of Enrollment into CHIP and to select a Contractor and Primary Care Provider (PCP).

A. Enrollment of Members with a Contractor

As part of the application process for coverage under CHIP, a Member shall select a Contractor. Members will have thirty (30) calendar days to select a Contractor.

Members who fail to make a voluntary Contractor selection will be subject to Auto Enrollment with a Contractor by the Division. Auto Enrollment rules will include provisions to consider the following in the order listed below:

1. **Family History and Prior Enrollment in CHIP:** The Division will assign the CHIP Member to a Contractor if the Member and/or individuals in the Member's Case Identification Number are or were enrolled with a particular Contractor as part of CHIP within the past two (2) months. If the Division does not identify that the Member and/or individuals in the Member's Case Identification Number were enrolled in a Contractor under CHIP, the Division will check whether the Member was enrolled previously in the CHIP Program with a particular Contractor.
2. **Prior Enrollment in the CHIP Program:** The Division will assign a Member to a Contractor if the Member was enrolled with a particular CHIP Contractor within the past two (2) months. If the Division does not identify prior CHIP Enrollment, the Division will review the Member's prior claims history.
3. **Prior Claims History:** The Division will review claims data and encounters from CHIP, CHIP Program, and Medicaid Fee-for-Service Program during the last six (6) months. The Division will assign each Member to the Contractor with the highest number of claims for a participating Contractor. In cases where the number of highest claims is equal across more than one Contractor, the Division will perform a review for the most recent date of service.
 - a. **Date of Service:** The Division will assign the Member to the CONTRACTOR with the most recent date of service for a participating Contractor. If there are identical most recent dates of service across more than one Contractor, the Division will perform a review for the most recent transaction control number, which uniquely identifies each claim.
 - b. **Transaction Control Number:** The Division will assign the Member to the CONTRACTOR with the most recent transaction control number, which is a unique 17-digit identifier for a claim assigned by the Medicaid Management Information System (MMIS).

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

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

B. Choice of a Health Care Professional

The Contractor shall offer each Member the opportunity to choose from at least two (2) network PCPs. The Contractor shall encourage Members to select a PCP to serve as a Medical Home. 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 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 must place Member PCP on all Member cards.

If the Contractor elects to assign Members to a PCP, it 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 thirty (30) calendar days after Contract execution and must 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 PCPs:** 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 or have a written agreement with a physician who has admitting privileges at a hospital appropriate for the patient needing admission);
 - 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. **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 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 and send updated Member card with name of PCP.

C. **Enrollment Period**

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

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

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

D. 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 standard mail, in envelopes marked with the phrase "Return Services Requested" as the medium for providing the Member identification information packet. The Division must receive a copy of this packet on an annual basis for review and approval at least thirty (30) calendar days before implementation, or at any point when changes are made to the packet. The Division will work to review and approve within fifteen (15) calendar days any changes to the packet made between annual reviews. At a minimum, the Member information packet shall include:

1. An introduction letter;
2. A CHIP Member identification card;
3. Information about how to obtain a copy of a Provider directory in compliance with 42 C.F.R. § 438.10(f)(6) at a minimum;
4. The Division approved Section 1557 Long Form Non-Discrimination Notice with the appropriate 15 language Taglines;
5. Information regarding the Member's disenrollment rights; and
6. 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, the Division approve Section 1557 Long Form Non-Discrimination Notice with the appropriate 15 Language Taglines, and the Member's disenrollment rights. However, the complete Member Information Packet must be supplied upon Member request.

E. Enrollment Verification

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

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

F. **Disenrollment**

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

1. No longer qualifies for CHIP under the eligibility categories in the eligible population; or
2. Becomes eligible for Medicaid coverage;
3. Becomes institutionalized in a public institution or enrolled in a waiver program; or
4. Becomes eligible for Medicare coverage.

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

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

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 notify the Division of Members identified with a diagnosis related to pregnancy within seven (7) calendar days of identification through a report, in a format and manner to be specified by the Division. If the Member is determined to be eligible for Medicaid, the Division will transmit a termination of eligibility date to the Contractor, along with the code indicating the reason for termination, via the eligibility/enrollment update. Coverage will continue until such time as the Contractor receives a termination code from the Division.

The Contractor may not request disenrollment of a Member because of an adverse change in the Member's health status, or because of the Members' utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Member's special needs except when the Member's

continued enrollment in the Contractor impairs the Contractor's ability to furnish services to either this particular Member or other Member(s). 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 and Enrollment into another 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; or
6. When the Division imposes intermediate sanctions, as defined by 42 U.S.C. § 1396u-2; on the Contractor and allows Members to disenroll without cause. In this event, Contractor shall be responsible for Member notification of ability to disenroll without cause.

Member requests for Disenrollment must be directed to the Division 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. If the Division fails to make a disenrollment determination within the specified time frames, the disenrollment will be considered approved.

G. Disenrollment of Custodial Nursing Home Residents

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

H. Disenrollment of Medicare Recipients

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

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

I. Re-Enrollment and Retroactive Eligibility

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

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

J. Member Listing Report

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

The Member Listing Report shall be provided to the Contractor 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 frames for identification card issuance and PCP notification shall be extended by one (1) business day for each day the Member Listing Report is delayed. The Division and the Contractor shall reconcile each Member Listing Report as expeditiously as is feasible but no later than the twentieth (20th) day of each month. Member Listing must be uploaded by the first day of the month by Contractor and Subcontractors.

K. Enrollment Discrimination

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

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

The Contractor shall not discriminate against individuals eligible to enroll or on the basis of race, color, religion, national origin, sex, sexual orientation, gender, gender identity or disability, 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, religion, national origin, sex, sexual orientation, gender, gender identity or disability, limited English proficiency, marital status, political affiliation, or level of income.

The Contractor shall not discriminate against individuals eligible to enroll 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 liquidated damages in accordance with Section 15, Non-Compliance and Termination, of this Contract if the Contractor is in violation of this section.

L. Special Rules for American Indians

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

Indians who are enrolled in a non-Indian managed care entities and eligible to receive services from a participating I/T/U Provider, to elect that I/T/U as his or her Primary Care Provider, if that I/T/U participates in the network as a Primary Care Provider and has capacity to provide the services.

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 G, Reporting Requirements, of this Contract.

A. Covered Services

The Contractor shall provide all Medically Necessary covered services allowed under CHIP in accordance with the State Health Plan. Coverage includes the Mississippi Division of Medicaid State Plan, also known as the Benchmark Plan, plus additional coverage and the Contractor shall provide Covered services set forth in Exhibit B, Covered Services, of this Contract (for reference only). The Contractor shall ensure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope); that no incentive is provided, monetary or otherwise, to Providers for withholding from a Member's Medically Necessary Services. The Contractor guarantees it will not avoid costs for covered services by referring Members to publicly supported resources, in accordance with 42 C.F.R. § 457.950. The Contractor shall make available accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this Contract.

The Contractor will not impose any pre-existing medical condition exclusion for covered services contained in this Contract, in accordance with 42 C.F.R. § 457.480 and Section 2102(b)(1)(B)(ii) of the Act.

B. Emergency Services

The Contractor will provide all inpatient and outpatient Emergency Services in accordance with 42 C.F.R. §438.114. The Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the Contractor. The Contractor shall have policies that address emergency use of services in an inpatient and outpatient emergency setting.

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

1. A Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would have the outcome of placing the health of the individual (or pregnant woman and unborn child) in serious jeopardy, or would result in serious impairment to bodily functions, or would result in serious dysfunction of any bodily part.
2. The Contractor, or the Member's primary care Provider (PCP), instructed the Member to seek Emergency Services.

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

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

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

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

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 an Out-of-network Provider that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain, improve or resolve the Member's stabilized condition if:

1. The Contractor does not respond to a request for pre-approval within one (1) hour;
2. The Contractor cannot be contacted;
or
3. The Contractor representative and the treating physician cannot reach an agreement concerning the Member's care and a physician from the Contractor's Provider Network is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a physician from the Contractor's Provider Network and the treating physician may continue with care of the Member until a Contractor physician is reached or one of the criteria of 42 C.F.R. § 422.113(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 physician from the Contractor's Provider Network with privileges at the treating hospital assumes responsibility for the Member's care;
2. A physician from the Contractor's Provider Network assumes responsibility for the Member's care through transfer;
3. A Contractor representative and the treating physician reach an agreement concerning the Member's care; or
4. The Member is discharged.

D. Well-Baby and Well-Child Services and Immunization Services

The Contractor shall provide Well-Baby and Well-Child Care services, including vision screening, laboratory tests and hearing screenings, according to the recommendations of the U.S. Preventive Services Task Force. Vision and hearing screenings shall be included as part of periodic Well-Child assessments.

the Contractor must have written policies and procedures related to the provision of the full range of Well-Baby Care, Well-Child Care, and childhood and adolescent immunizations services as defined in, and in accordance with, the State Health Plan, 42 C.F.R. § 457.495, and the provisions of this Contract. Services shall include, without limitation, periodic health screenings, and appropriate and up-to-date immunizations using the immunization schedule for all Members recommended by the Advisory Committee on Immunization Practices (ACIP). The Contractor shall make all reasonable efforts to identify all Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations. Immunizations are purchased by the Division and distributed through the Mississippi State Department of Health. The Contractor shall reimburse Providers for the administration of the immunizations.

The Division requires that the Contractor cooperate to the maximum extent possible with efforts to improve the health status of Mississippi Medicaid Members, and to actively work to improve the percentage of Members receiving appropriate screenings, and meet or exceed the Division's targets.

The following minimum elements must be included in the periodic health screening assessment for children:

1. Comprehensive health and development history (including assessment of both physical and mental development);
2. Measurements (e.g., head circumference for infants, height, weight, body mass index);

3. Comprehensive unclothed physical examination;
4. Immunizations appropriate to age and health history;
5. Assessment of nutritional status;
6. Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);
7. Vision screening;
8. Hearing screening;
9. Dental and oral health assessment; and
10. Developmental and behavioral assessment.

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 Well-Baby and Well-Child Care services and immunization services provision requirements in the following areas:

1. Initial visit for newborns;
2. Well-Baby and Well-Child Care services and reporting of all assessment 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. Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate; and
4. A process for outreach and follow-up to Members with special health care needs.

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

E. Behavioral Health/Substance Use Disorder

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

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

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

F. Prescription Drug Services

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

The Contractor shall provide pharmacy services to Members enrolled in CHIP. The Contractor shall comply with the Mississippi Pharmacy Practice Act (Miss. Code Ann. § 73-21-71, *et. seq.*) 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. The contractor shall not reject claims for any drugs in a retail pharmacy for the purpose of redirecting prescriptions to the contractor's mail order pharmacy and/or contracted specialty pharmacy.

The Contractor must use the most current version of the Mississippi Division of Medicaid Universal Preferred Drug List (PDL) which is subject to periodic changes. The Contractor must use the PDL and prior authorization criteria 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 Office of Pharmacy's Director. The Executive Director of the Division has final authority on drugs with preferred status on the PDL and/or drugs for Prior Authorization. The Contractor shall not promote any preferred drugs over other preferred drugs.

The Contractor must refer to the Division's website, specifically the Pharmacy Services Page, for a current listing of prescription drugs on the PDL to ensure continuity of care for Members. Pursuant to 438.10(i), the Contractor must make available in paper and electronic

form the following Preferred Drug List information: which medications are covered (generic and name brand), what tier each medication is on, if applicable, and the information must be made available on the Contractor's website.

Benefits will be provided for over the counter medications which are listed on the MS Medicaid Covered Over-the-Counter (OTC) Drugs list and obtained with a prescription.

The Contractor shall establish a unique BIN / PCN number for the processing of Mississippi Medicaid CHIP Members pharmacy claims for the purpose of separating the Contractor's third party private pharmacy Provider claims from the Medicaid CHIP claims. The remittance advice statements must adhere to industry standards and be in a user-friendly format and approved by the Division and as defined by the Division.

The Contractor's reimbursement methodology used by the Pharmacy Benefits Manager ("PBM") must be based on the actual amount paid by the PBM to a pharmacy for the dispensing fee and the ingredient cost.

The Contractor must ensure its subcontracted PBM does not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component related to the claim adjudication process.

The Contractor shall provide the Division's Office of Pharmacy electronic access/viewing rights of the contracted Pharmacy Benefits Manager's real-time pharmacy point-of-sale claims system and testing rights in the PBM's pharmacy point-of-sale claims testing environment.

The Contractor/Subcontractor must follow the Division's current reimbursement methodology to reimburse pharmacy Providers for pharmacy point of sale claims.

The Contractor must include a written description of assurances and procedures policies under the proposed PBM Subcontract such as an independent audit to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The Contractor must provide a plan documenting how it will monitor these Subcontractors. The assurances and procedures policies must be submitted for the Division's review 30 days prior to initiating any PBM Subcontract.

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

The Contractor may approve drugs outside the PDL in accordance with Section 5.I, Prior Authorizations, 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. 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 dispensing limits for any drug may be restricted to a thirty (30)-day supply at one time except for those drugs listed on the 90 day list and those defined in Administrative Code Title 23 found on the Division's website. A Member must be allowed to obtain an early refill of a prescription drug under certain circumstances, such as change of dosage during the course of treatment, for lost or destroyed medication, or when the Member is going on vacation. The Member or his/her representative may be required to contact the Contractor to obtain authorization for any early refill or advance supply of a medication.

The Division does not collect CHIP drug rebates. However, the Contractors must report any rebates collected to the Division.

The Division must be informed prior to any and all Medicaid pharmacy audits. The Contractor must complete all audits of a Provider claim no later than one year after receipt of a clean claim. If the audit indicates that the Contractor is due a refund from the Provider, the Contractor must send the Provider written notice of the basis and specific reasons for the request, the Contractor must give the Provider an opportunity to Appeal and may not attempt to recover the payment until the Provider has exhausted all Appeals rights And the Division has approved of the findings.

G. Pharmacy Lock-In Program

The Contractor shall submit a monthly report, as defined by the Division, providing information on the Pharmacy Lock-In program in order to monitor services received and reduce unnecessary or inappropriate utilization, as defined by the Division. The Contractor shall submit their policy and criteria for a Member to be locked in.

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

H. Enhanced Services

The Contractor may provide enhanced services that exceed the benefits or services provided under CHIP 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 the 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 in a format to be specified by the Division.

I. Medical Prior Authorizations

1. General Requirements

The Contractor shall be required to use InterQual when developing medical necessity appropriateness of service guidelines. The Contractor is not required to use this utilization management criteria for non-InterQual prior authorizations.

The Contractor must have written policies and procedures for the Prior Authorization of services, which must comply with this Contract and 42 C.F.R. § 457.495. The Division must receive Prior Authorization criteria and associated policies and procedures.

The Contractor shall demonstrate high quality administrative and clinical leadership in prior authorization services, which must comply with Federal and State laws and regulations, the Division policies and formal memorandums. The Division will provide assistance as needed with interpretation and clarification of the Division policies and will notify the Contractor as changes are made that affect the program. Any instances of discrepancies in interpretation of the Contract, policies or program requirements between the Contractor and the Division will be decided at the discretion of the Division. The requirements in this section are applicable to all review functions.

The Contractor shall have established procedures and sufficient staffing to receive all review requests, supporting medical documentation and adhere to specific processing requirements, regardless of the mode of receipt. Staffing requirements must be in accordance with Section 1. L. Administration, Management, Facilities and Resources.

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

Completion of a first level determination is one (1) of the following:

- a. Authorization of services by the first level reviewer;
- b. Authorization through the automated rules system, when appropriate;
- c. Referral to second level review;

- d. Pending of the review based on a request for additional information from the Provider;
or
- e. Technical denial of the request due to administrative policy rules, as defined by the Division.

Completion of a second level determination is one (1) of the following:

- a. Authorization of services by the second level reviewer;
- b. Denial, modification or reductions of services by the second level reviewer;
- c. Pending the review based on Contractor request for additional information from the Provider; or
- d. Technical denial of the request due to Federal and State laws and regulations, the Division policies and/or formal memorandums.

The Contractor shall ensure denials, modifications, or reductions in services by the second level reviewer are made by a physician reviewer licensed in the State of Mississippi and of the same specialty as a result of the second level review.

The Contractor shall have the capability and established procedures to receive retrospective review requests by web-based submission, facsimile, or mail. A retrospective review is performed when a service has been provided and no authorization is obtained, or at the discretion of the Division. (The Division provides retroactive eligibility review for a Member that was not eligible for CHIP benefits at the time of service.)

The Contractor shall pend a service authorization review request if the Provider submits a request for authorization with incomplete, inadequate, or ambiguous information. The Contractor shall seek clarification or request that the Provider submit all required information, including additional supporting clinical information as necessary. The Contractor shall initiate a process of placing a request on hold (pending) until additional information has been received.

The Contractor shall suspend a review for services when the review has been pended because additional information is required and the requested information is not submitted by the due date. If the requested information is not submitted by the due date, the Contractor must have a process for technically denying the services for failure to submit additional information required to perform the review.

The Contractor shall issue a technical denial for services when the case does not meet Federal and State laws and regulations, the Division policies and/or formal memorandums or is technically insufficient.

The Contractor shall have the capability and established procedures to ensure all ordering and referring physicians or other professionals providing services under the State plan are enrolled as a participating CHIP Provider, prior to authorizing review requests.

The Contractor shall generate an authorization number when a case meets all policy and

medical criteria necessary for authorization of the services requested.

Except as otherwise noted, the Contractor shall notify CHIP Members of the denied requests in writing via certified U.S. Mail, and shall ensure that the Member notice contains the medical and/or technical basis for the denial. The notice shall set forth the Flesch-Kincaid, or other approved standard, readability scores at or below sixth (6th) grade reading level and the Contractor shall certify compliance therewith. The notice shall use easily understood language and format in a font no smaller than 12-point. The notice shall be available in English and such other language as the Division may require at any time with proper notice to the Contractor; and shall be available in alternative formats as required for the special needs of Members.

The Contractor shall provide written notices to Providers through an online web-based system and via facsimile notifications. The Contractor shall also allow verbal notification of pended reviews to Providers unable to receive written facsimile notification. The Contractor shall have a process to document verbal notifications. The Division may request the documentation at any time with proper notice to the Contractor.

The Contractor's written notice of denials, modifications, or reductions shall include a statement that a Provider, attending physician, or Member/representative/responsible party who is dissatisfied with the review determination is entitled to a reconsideration of the review outcome. The written notice shall also explain the method by which a Provider, attending physician, or Member/representative/responsible party can request a reconsideration of the review outcome.

The Contractor shall conduct reconsiderations and make determinations upholding, modifying, or reversing the review outcome by taking into consideration all pertinent information, including any additional or new information that may be presented during the reconsideration.

The Contractor must provide, at a minimum, a reconsideration process for reviews in which the decision is a:

- a. Denial, modification, or reduction of services/items based on medical necessity;
- b. Denial based on Federal and State laws and regulations, the Division policies and/or formal memorandums that excludes coverage;
- c. Certain technical denials as defined by the Division;
- d. Quality issue, or
- e. Other adverse decisions as defined by the Division.

The Contractor shall have the capability to accept and document reconsideration requests by web-based submission, telephone, facsimile, or mail, and shall have dedicated telephone and facsimile numbers for reconsiderations.

The Contractor shall have established procedures to notify individuals that the reconsideration request was received by the Contractor and the individual has the

opportunity to provide additional information within 10 business days from the date on the Contractor's notification letter.

The Contractor shall ensure that a second physician not involved in the initial decision reviews the reconsideration request, the original information, and any additional information submitted with the reconsideration request and make a determination. The second physician or reconsideration physician reviewer shall be licensed in the state of Mississippi and of the same specialty as the attending physician.

The Contractor shall provide written notification of reconsideration determinations.

If the reconsideration determination was upheld or any portion was not approved as requested, the Contractor's written notice shall include a statement explaining the Member, representative, or responsible party has the right to request an Independent External Review. The notice shall set forth the Flesch-Kincaid, or other approved standard, readability scores at or below sixth (6th) grade reading level and the Contractor shall certify compliance therewith. The notice shall use easily understood language and format in a font no smaller than 12-point. The notice shall be available in English and such other language as the Division may require at any time with proper notice to the Contractor; and shall be available in alternative formats as required for the special needs of Members.

The Contractor shall have the capability to conduct Retroactive Eligibility Reviews, a review conducted after services are provided to a Member and the Member is retroactively determined to be eligible for CHIP. The Contractor shall allow the Provider ninety (90) calendar days from the date of eligibility determination to submit authorizations for service rendered on or after the retroactive eligibility date. (Example: John Doe applies for CHIP on January 1, 2017 and the Division determines eligibility on April 1, 2017. John Doe is retroactively eligible for CHIP effective January 1, 2017. As a result of the retroactive eligibility, the Provider shall be allowed ninety (90) calendar days from the date of eligibility determination (April 1, 2017) to submit authorization requests for dates of services on or after January 1, 2017. For dates of service on or after April 1, 2017, the Provider should obtain a prior authorization for services and in some instances obtain a retrospective authorization.)

2. Pharmacy Prior Authorizations

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 not promote adherence to a PDL or preferred drug program other than that which has been approved by the Division. 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 prescription drugs are made in a clinically sound manner. The Division's Office of Pharmacy's approval is required for all Clinical Edit policies.

The Division must receive this criteria and coverage policies for advanced written approval forty-five (45) calendar days prior to implementation.

3. Medical and Pharmacy 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 a Web-based, electronic review request system accessible to Providers and the 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 Mississippi Health Information Network (MS HIN) 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 login. 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 HIPAA ASC X12 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 Personally Identifiable Information (PII) and Protected Health Information (PHI) transactions for Prior Authorization requests requiring attachments.

The Contractor shall create a “smart” electronic authorization request form, customized for each service that requires certification. The form must be standardized for all CHIP Contractors and must receive prior approval by the Division. The form must be submitted by the Contractor to the Division for review and approval thirty (30) calendar days prior to use. The Contractor shall design this form so that it reduces the chances of technical denials due to incorrect or missing information.

The Contractor’s web-based electronic review request system shall be required to follow all algorithms, criteria and processes as defined by the Division. The Division must review and approve said processes prior to the Contractor’s implementation. Upon approval, Division-approved smart electronic prior authorization PA algorithms, criteria, forms and processes should be implemented immediately, or within five business days.

The Contractor shall provide training in the use of the Web-based system and the equipment required for the Division online access to the Web-based system. The Division staff shall be given access to the Contractor’s electronic system for the purpose of monitoring Prior Authorizations and submitted paid claims (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 Division of Medicaid processes Prior Authorization requests for prescription drugs within twenty-four (24) hours of receiving the request. The Contractor shall adhere to this time frame.

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

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

business day or three (3) calendar days) for the requestor to submit medical information to the Contractor.

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

The Contractor must expedite authorization for services when the Provider indicates or the Contractor determines that following the standard authorization decision time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. The Contractor must provide an Expedited Authorization 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. The extension request to the Division applies only after the Contractor has received all necessary medical information to render a decision and the Contractor requires additional calendar days to make a decision. The Contractor must provide to the Division the reason(s) justifying the additional calendar days needed to render a decision. The Division will evaluate the Contractor's extension request and notify the Contractor of decision within three (3) calendar days and/or two (2) business days of receiving the Contractor's request for extension.

J. 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 (Miss. Code Ann. § 41-41-201, *et seq.*).

The Contractor shall reflect changes in State law in its written advance directives information as soon as possible, but no later than ninety (90) days after the effective date of the change.

K. Member Notification

The Contractor shall mail written notice to Members of the opportunity for a Member Appeal in the event of the termination, suspension, or reduction of previously authorized

Covered Services within ten (10) calendar days of the date of the Adverse Benefit Determination for previously authorized services as permitted under 42 C.F.R. § 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.

The Contractor must give notice of an Adverse Benefit Determination by the date of the Adverse Benefit Determination when any of the following occur:

- a. The Member has died;
- b. The Member submits a signed written statement requesting service termination;
- c. The Member submits a signed written statement including information that requires service termination or reduction and indicates that the Member understands that service termination or reduction will result;
- d. The Member has been admitted to an institution in which he is ineligible for CHIP services
- e. The Member's address is determined unknown based on returned mail with no forwarding address;
- f. The Member is accepted for CHIP services by another local jurisdiction, state, territory, or commonwealth;
- g. A change in the level of medical care is prescribed by the Member's physician;
- h. The notice involves an adverse determination with regard to preadmission screening requirements; and
- i. If applicable, the transfer or discharge from a facility will occur in an expedited fashion as described in 42 C.F.R. § 483.12(a)(5)(ii).

L. Immunization Schedules

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

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

M. Member Financial Liability

The Contractor shall educate network Providers to collect Co-Payments from Members in accordance with Table 2.

Table 2. Allowable Cost Sharing by FPL

Requirement	≤150% FPL	151% to 175% FPL	176% to 209% FPL
Per Physician Visit	None	\$5.00	\$5.00
Per Emergency Room Visit	None	\$15.00	\$15.00
Out-of-Pocket Maximum	N/A	\$800.00	\$950.00

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

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

1. The Contractor shall not apply Cost Sharing to the following services: preventive services, including immunizations, Well-Baby and Well-Child Care Services, routine preventive and diagnostic dental services, routine dental fillings, routine eye examinations, eyeglasses, and hearing aids in accordance with 42 C.F.R. § 457.520.
2. The Contractor shall not apply Cost Sharing to the costs of Emergency Services that are provided at a facility that does not participate in the Contractor's Provider Network beyond the Cost Sharing amounts specified in Table 2, in accordance with 42 C.F.R. § 457.515(f).
3. Federal law prohibits charging premiums, deductibles, coinsurance, Co-Payments, or any other Cost Sharing to Native Americans or Alaskan Natives. The Contractor shall be responsible for educating network Providers regarding the waiver of Cost Sharing requirements for this population.
4. Members shall not be liable for payments to Providers for Covered Services provided other than the Co-Payments referenced within this Contract.

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

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

SECTION 6 – MEMBER SERVICES

The Contractor must submit reports related to Member services in accordance with Section 10, Reporting Requirements, and Exhibit G, 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 (7:30 a.m. to 5:30 p.m. Central Time Zone, Monday through Friday) and one (1) evening per week (5:30 p.m. to 8:00 p.m. Central Time Zone) 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/Substance Use Disorder 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/Substance Use Disorder-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. Explaining Member rights and responsibilities;
- d. Handling, recording and tracking Member Grievances and Appeals in accordance with this Contract;
- e. Referring Members to the Fraud and Abuse Hotline; and
- f. 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 the 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. All call center scripts must be submitted by the Contractor to the Division for review and approval thirty (30) calendar days prior to use.

Under no circumstances will unlicensed Member services staff provide health-related advice to Members requesting clinical information. In such cases, these calls must be immediately transferred to clinical personnel 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 upon request within five (5) calendar days. The Contractor will make recordings and associated transcripts available to the Division upon request within five (5) business days. The Contractor shall maintain the recordings and associated transcripts for at least six (6) months.

4. Staff Training

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

5. The Contractor shall ensure its staff is trained to respond appropriately to pharmacy prior authorization inquiries and other inquiries regarding Pharmacy Services.
6. 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.E, Liquidated Damages, 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. The Division will work to review and approve work plan and quarterly updates within thirty (30) calendar days.

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

The Contractor may also be required to conduct, in collaboration with the Division, Workshops targeting Members. For such trainings in collaboration with the Division, 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. The Contractor must submit material used at the Workshops to the Division for approval at least thirty (30) calendar days prior to the Workshop.

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 CHIP Member identification number, effective date of coverage, the name and address of the Contractor, the name of the Member's PCP (if PCP name is 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, a telephone number for Providers to verify eligibility, instruction on obtaining Prior Authorizations including telephone number to call, Cost Sharing amounts and Out-of-Pocket Maximum, and a Contractor identification number, if applicable. The Contractor must submit and receive approval of the identification card from the Division

fifteen (15) calendar days 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 shall utilize at least standard mail, in envelopes marked with the phrase “Return Service 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. The Contractor shall submit reports on returned Member identification cards in accordance with Section 10.D, Member Identification Card Reports.

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 maintain a Member handbook specific to CHIP. The Contractor shall submit a copy of the Member Handbook to the Division for approval sixty (60) calendar days prior to distribution and as part of the readiness review process. 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 any changes to the initial handbook, the Division will work to review and approve any changes within forty-five (45) calendar days. 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 CHIP 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. Terms and conditions under which Member eligibility and coverage for CHIP may be terminated
3. A general description of covered services, including the appropriate utilization of services and eligibility determination process
4. A description of the Members subject to Co-Payments and Out-of-Pocket Maximums, the amount of the Co-Payments and Out-of-Pocket Maximums, the mechanism for Members to make Co-Payments for required charges, and a Provider's right to refuse service of Co-Payments are not paid by the Member
5. Procedures to be followed if Member wishes to change Contractors
6. PCP roles and responsibilities in serving as a Medical Home in directing care
7. Information about choosing and changing PCPs
8. 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 Out-of-network Providers and any referral requirements; and
 - e. Information about family planning services.
9. 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/Substance Use Disorder-related profession twenty-four (24) hours, seven (7) days per week;
 - c. A description of availability of and instructions on how to utilize the twenty-four (24) hours, seven (7) days per week nurse advice line;
 - d. A description of Well-Baby and Well-Child Care services and instructions advising Members about how to access such services;

- e. A description of all available covered services, including Behavioral Health/Substance Use Disorder, dental, maternity, pharmacy, and preventive services, and an explanation of any service limitations, referral, and Prior Authorization requirements. This description should include that the Member may receive a minimum of a three (3)-day emergency supply for prior authorized drugs until authorization is completed;
 - f. A description of family planning services and how Members may obtain benefits from Out-of-network Providers;
 - g. Information about the features of Care Management, the responsibilities of the Contractor for coordination of Member care, and the Member's role in the Care Management process;
 - h. Procedures for notifying Members of the termination or change in any benefits, services, or locations;
 - i. A description of the enhanced services the Contractor offers, if applicable;
 - j. A description of the Contractor's confidentiality policies;
 - k. An explanation of any service limitations or exclusions from coverage; including limitations that may apply to services obtained from Out-of-network Providers;
 - l. 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;
 - m. Circumstances under which an eligible Member may be involuntarily disenrolled from the Contractor and enrolled into another Contractor, and/or from CHIP without any insurance coverage.
10. Instructions on reporting suspected cases of Fraud and Abuse to the Fraud and Abuse Hotline

11. Member Grievances and Appeals

- a. A description of the Member Grievance and Appeals procedures including, but not limited to:
 - i. The definition of a Member Grievance and Appeal and who may file each of these;
 - ii. Information on filing Member Grievances and Appeal procedures;
 - iii. Time frames to register and receive a response regarding a Member Grievance or Appeal with the Contractor as described in this Contract;

- iv. The availability of assistance in the filing process, including making available reasonable assistance in completing forms and taking other procedural steps;
- v. The toll-free numbers that the Member can use to file a Member Grievance or an Appeal by telephone;
- vi. A description of the continuation of Enrollment process required by 42 C.F.R. § 457.1170 and information describing how the Member may request continuation of Enrollment;
- vii. Information on how the Member may be required to pay the cost of services furnished while the Member Appeal is pending, if the final decision is adverse to the Member; and
- viii. Telephone numbers to register Member Grievances regarding Providers and the Contractor.

12. Emergency Medical Care

- a. How to appropriately use Emergency Services and facilities, including a description of the services offered by the Member services call center;
- b. Explanation of the definition of an emergency using the “prudent layperson” standard as defined by this Contract and in accordance with 42 C.F.R. § 438.114, a description of what to do in emergency, instructions for obtaining advice on getting care in an emergency, and the fact that Prior Authorization is not required for Emergency Services. Members are to be instructed to use the emergency medical services available or to activate Emergency Services by dialing 911;
- c. A description of how to obtain Emergency Transportation and other medically necessary transportation;
- d. Availability in the Provider directory of locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered herein;
- e. Information indicating that Emergency Services are available without Prior Authorization and out-of-network Emergency Services are available without any financial penalty to the Member;
- f. Information indicating that Members have a right to use any hospital or other setting for emergency care; and
- g. Definition of and information regarding coverage of Post-Stabilization Care Services in accordance with 42 C.F.R. § 422.113(c).

13. Member Identification Cards

- a. A description of the information printed on the Member Identification Card; and
- b. A description of when and how to use the Member Identification Card;

14. Interpretation and Translation Services

- a. Information on how to access verbal interpretation services, free of charge, for any non-English language spoken [42 C.F.R. § 438.1 O(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)].

15. 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.

16. Member Responsibilities

- a. A description of procedures to follow if:
 - i. The Member's family size changes;
 - ii. The Member moves out of state or has other address changes; and
 - iii. The Member obtains or has health coverage under another policy or there are changes to that coverage.
- b. Adverse Benefit Determinations the Member can make towards improving his or her own health, Member responsibilities and any other information deemed essential by the Contractor;
- c. Information about the process that Members and Providers must follow when

requesting inpatient Prior Authorization and how to notify the Contractor of an inpatient admission;

- d. Information about advance directives such as living wills or durable power of attorney, in accordance with 42 C.F.R. § 422.128 and the State's Uniform Health Care Decisions Act (Miss. Code Ann. § 41-41-201, et. seq.; and
- e. Information regarding the Member's repayment of capitation premium payments if Enrollment is discontinued due to failure to report truthful or accurate information when applying for CHIP;

17. Contractor Responsibilities

- a. Additional information that is available upon request, including information about the structure and operation of the Contractor;
- b. Additional information about physician incentive plans as set forth in 42 C.F.R. § 438.6(h); and
- c. Notification to the Member that the Division should be notified if the Member has another health insurance policy or Creditable Coverage.

E. **Provider Directory**

The Contractor shall maintain a Provider directory specific to CHIP. 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 Network Providers in the Member's area;
- 2. Identification of PCPs and PCP groups, specialists, and hospitals, facilities, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (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; and
- 5. Identification of hours of operation including identification of Providers with non-traditional hours (Before 8 a.m. or after 5 p.m. Central Time Zone or any weekend hours).

the Contractor shall make available hard copy Provider directories in the Division Regional

Offices, the Contractors' 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 fifteen (15) calendar days 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, but not limited to, all marketing materials, plan booklets, descriptions and information, instructional materials, policies and procedures disclosures, notices and handbooks must meet requirements specified under 42 C.F.R. § 438.10, 42 C.F.R. Part 92, and meet the following requirements:

1. Documents are comprehensive yet written to meet a Flesch-Kincaid, or other Division-approved standard, total readability level at or below the sixth (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 contain font size no smaller than 12 point.
4. Documents can be easily made available in alternative formats and electronically by the Contractor and are available upon request and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, in accordance with 42 C.F.R. § 438.10(d)(6)(iii).
5. Documents include large print taglines and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.
6. Significant publications and communications, including small-sized significant

publications and communications, shall contain the notices and taglines required by 45 C.F.R. § 92.8.

Member information required under 42 C.F.R. §438.10 may be provided electronically by the Contractor provided that all of the conditions established by 42 C.F.R. §438.10(c)(6) are met.

All Enrollment, Disenrollment and educational documents and materials made available to Members by the Contractor must be submitted to the Division for review and approval thirty (30) calendar days prior to release, unless specified elsewhere in this Contract. The Contractor must review all materials on an annual basis and provide a list of these materials to the Division annually indicating the review date. If the Contractor revises these materials, the Contractor will submit the updated materials to the Division for review and approval highlighting and using a redlined format for changes. 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.X, Deliverables, of this Contract. In such cases, the Division will specify the time frame for submission of Deliverables. The Division will notify the Contractor of the time frame it will require for review of Deliverables.

The Contractor shall also make verbal interpretation services available free of charge to each Member for all non-English languages and shall institute a mechanism for all Members who do not speak English to communicate effectively with their PCP and with Contractor staff and Subcontractors. Verbal interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education [42 C.F.R. § 438.10(d)]. The Contractor must provide auxiliary aids such as Teletypewriter (TTY), Telecommunications Device for the Deaf (TDD), or Video Phones (VP) 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. Additional Requirements for Communication with Contractor's Members

The Contractor shall submit all communication materials with its Members to the Division thirty (30) calendar days prior to the planned distribution and the Division must approve these materials before they are released.

Communication activities must comply with all relevant Federal and State laws, including, when applicable, the Health Insurance Portability and Accountability Act, the anti-kickback

statute, and civil monetary penalties prohibiting inducements to Members. The Contractor may be subject to sanctions if it offers or gives something of value to a Member that the Contractor knows or should know is likely to influence the Member's selection of a particular Provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid. Additionally, the Contractor is prohibited from offering rebates or other cash inducements of any sort to its Members, without prior written approval from the Division. The Contractor may be subject to liquidated damages, a fine, and/or sanctions if it conducts any communication activity that is not approved in writing by the Division.

1. Allowable Contractor Communication Activities

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

- a. Distribution of communication materials to Members pre-approved by the Division; and
- b. The Contractor is allowed to offer non-cash incentives to its Members for the purposes of rewarding for compliance in immunizations, prenatal visits, participating in Care Management, or other behaviors as pre-approved by the Division. On a case-by-case basis, the Division may approve cash-value incentives upon request by the Contractor, and if adequately justified. The Contractor shall analyze Member data 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 written approval at least thirty (30) calendar days prior to planned implementation.

2. Prohibited Communication Activities

The following are prohibited communication activities targeting Members under this Contract:

- a. Engaging in any informational activities which could mislead, confuse, or defraud Contractor's Members or misrepresent the Division;
- b. 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.

H. Internet Presence/Website

The Contractor shall develop, host and maintain a website specific to CHIP. 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 Contractor must have the ability to link to the State's Medicaid 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 thirty (30) calendar days 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.

Contractor shall submit proposed final web content pertinent to the CHIP program to the Division for review and approval forty-five (45) calendar days prior to making the content available and as updated.

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 Medicaid 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; 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.

I. Marketing

All Marketing activities by the Contractor including, but not limited to the Contractor's development of marketing materials such as written brochures and fact sheets, shall be in accordance with 42 C.F.R. § 457.1224 and §438.104, with the exception of §438.104 (c) related to state agency review does not apply.

Marketing plans and materials must be distributed to the Contractor's entire service area as indicated in this Contract. Marketing plans and materials shall not mislead, confuse, or defraud the Members or the Division. Specifically, the Contractor cannot make any assertion or statement, whether written or verbal, that the Member must enroll in the Contractor in order to obtain benefits or to not lose benefits or that the Contractor is endorsed by CMS, the Federal or State government, or similar entity. The Contractor shall submit all Marketing materials to the Division 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-kick-back statute, and civil monetary penalties prohibiting inducements to Members. The Contractor may be subject to sanctions if it offers or gives something of value to a Member that the Contractor knows or should know is likely to influence the Member's selection of a particular Provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by CHIP. Additionally, the Contractor is being prohibited from offering rebates or other cash inducements of any sort to potential Members of the Contractor.

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 work to review within fifteen (15) calendar days. The Contractor may distribute Marketing materials to CHIP Members 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 liquidated damages, a fine and/or sanctions if it conducts any Marketing activity that is not approved in writing by the Division (42 C.F.R. § 438.700).

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 of promotional materials pre-approved by the Division;
- c. Pre-approved informational materials for media outlets including, but not limited to, television, radio, social media channels 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 the 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

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, email, texting, or other “cold call” Marketing of Enrollment at residences and Provider sites and events or venues of outreach targeting Members (42 C.F.R. § 438.104);
- c. Sending direct mailing (all Marketing mailings must be processed through the Division or its Agent);
- 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 the 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 Child Protection Services offices unless authorized in advance by the Division;
- m. No assertion or statement (whether written or verbal) that the Contractor is endorsed by 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).

J. 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 (42 U.S.C. § 2000d *et seq.*), as amended and as implemented at 45 C.F.R. Part 80; the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), as amended and as implemented by regulations at 45 C.F.R. Part 91; the Rehabilitation Act of 1973 (29 U.S.C. § 701 *et seq.*), as amended; Titles II and III of the Americans with Disabilities Act (42 U.S.C. § 12101 *et seq.*); 45 C.F.R. Part 84, 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 except as related to medically necessary services (42 CFR 438.210(a)(5)), and the timeframes set forth in 42 CFR 438.210(d)

The written policies and procedures shall also address the responsibility of Members to pay for unauthorized health care services obtained from non-participating Providers and their right to know the procedures for obtaining authorization for such services. The Contractor shall also have policies addressing the responsibility of each Member to cooperate with those providing health care services by supplying information essential to the rendition of optimal care, following instructions and guidelines for care that they have agreed upon with those providing health care services, and showing courtesy and respect to Providers and staff. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members. A copy of the Contractor's policies and procedures regarding Member rights and responsibilities shall be provided to all Network Providers and any Out-of-network Providers to whom Members may be referred.

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 the 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 (Pub.L. 105–33) which protects Members against balance billing by Subcontractors.

K. **Member Complaint, Grievance, Appeal and Independent External Review 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 or requests for an Independent External Review by Members. The Complaint, Grievance and Appeal policies and procedures shall be in accordance with 42 C.F.R. §457.1260 *et. seq.*, 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 E, Member Complaint, Grievance, Appeal, and Independent External Review Process, of this Contract, *except* for the Continuation of Benefits provision found in §438.420. 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 an Independent External Review following the outcome of the Appeal to Contractor, upon notification of a Contractor Adverse Benefit Determination, subsequent to an Appeal of the Contractor Adverse Benefit Determination. The Member must exhaust all Contractor level Appeal procedures prior to requesting an Independent External Review.

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.

Table 3 below and Exhibit E, Member Complaint, Grievance, Appeal, and Independent External Review 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, regardless of whether identified by the Member as a “Complaint”, received by any employee of the Contractor orally or in writing that is of a less serious or formal nature that is resolved within one (1) calendar day of receipt. Any Complaint not resolved within one (1) calendar day of receipt shall be treated as a Grievance.			

Party	Action	Time Frame	Extensions Available
Member, Provider on behalf of a Member, or Authorized Representative	Submit a Complaint	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Resolve a Complaint	Within one (1) calendar day	
Grievance: An expression of dissatisfaction, regardless of whether identified by the Member as a “Grievance”, received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the enrollee’s rights regardless of whether remedial action is requested. Grievance includes an enrollee’s right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.			
Member, Provider on behalf of a Member, or Authorized Representative	File a Grievance	At any time after the Grievance has occurred.	
Contractor	Confirm receipt of Grievance and expected date of resolution	Within five (5) calendar days of receipt of the Grievance	
Contractor	Resolve a Grievance	Within thirty (30) calendar days of the date the Contractor receives the Grievance or as expeditiously as the Member’s health condition requires	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)
Appeal: A request for review by the Contractor of an Adverse Benefit Determination related to a Member or Provider review by the Contractor of an Adverse Benefit Determination. In the case of a Member, the Adverse Benefit Determination may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member). In the case of a Provider, the Adverse Benefit Determination may include, but is not limited to, delay or non-payment for covered services			

Party	Action	Time Frame	Extensions Available
Member or Authorized Representative	File an Appeal	Within sixty (60) calendar days from the date on the Contractor's Adverse Benefit Determination notice	
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 thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires. No longer than 72 hours after the Contractor receives the request for an Expedited Resolution of an Appeal	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. §438.408(c)
Independent External Review: A review of any Adverse Benefit Determination conducted by the State or a Contractor other than the Contractor responsible for the matter subject to external review. In accordance with 42 C.F.R. §457.1150.			
Member or Authorized Representative	File a request for an Independent External Review	Within one hundred and twenty (120) calendar days from the date of the Contractor's notice of resolution.	

SECTION 7 – PROVIDER NETWORK

The Contractor must submit reports related to Provider Networks in accordance with Section 10, Reporting Requirements, and Exhibit G, 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 and shall provide payment that is not less than the level and amount of payment for which the Contractor would make for the services if the services were furnished by a Provider which is not a FQHC or RHC. The Contractor must contract with as many FQHCs and RHCs as necessary to permit Member access to participating FQHCs and RHCs without having to travel a significantly greater distance than the location of a non-participating FQHC or RHC. If the Contractor cannot satisfy this standard for FQHC and RHC access at any time, the Contractor must allow its Members to seek care from non-contracting FQHCs and RHCs and must reimburse these Providers at CHIP fees.

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

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

The Contractor shall ensure that its network of Providers is adequate to assure access to all covered services, and that all Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the covered services. The Contractor may not close their Provider Network for any Provider without prior approval from the Division. The Contractor must ensure that Provider selection policies and procedures do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

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 - Adult and	Two (2) within fifteen (15)	Two (2) within thirty (30) miles

Provider Type	Urban	Rural
Pediatric	miles	
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Specialists - Adult and Pediatric	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
General Dental Providers Adult and Pediatric	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Emergency Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within thirty (30) minutes or thirty (30) miles
Urgent Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	Not Applicable
OB/GYN	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Durable Medical Equipment Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Behavioral Health Providers (Mental Health Providers and Substance Use Disorder) (Adult and Pediatric)	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
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

In addition to the network adequacy requirements described above, the Contractor must demonstrate that there are sufficient Indian Health Care Providers participating in the Provider network of the Contractor to ensure timely access to services available under the Contract from such Providers for Indian enrollees who are eligible to receive services. The Contractor shall pay Indian Health Care Providers for covered services provided to Indian Members who are eligible to receive services from such Providers as described in 42 C.F.R. §438.14(b)(2). The Contractor shall permit any Indian who is enrolled with the Contractor and who is eligible to receive services from an Indian Health Care Provider primary care Provider participating as a network Provider, to choose that Indian Health Care Provider as his or her primary

care Provider, as long as that Provider has capacity to provide the services. Indian Members shall be permitted to obtain services covered under this Contract from Out-of-Network Indian Health Care Providers from whom the Member is otherwise eligible to receive such services. If access to covered services cannot be ensured due to few or no Indian Health Care Providers, the Contractor will be considered to have met these requirements if:

- a. Indian Members are permitted by the Contractor to access out-of-state Indian Health Care Providers; or
- b. If this circumstance is deemed to be good cause for disenrollment from both the Contractor and the CHIP program in accordance with 42 C.F.R. §438.56(c).

The Contractor must permit an out-of-network Indian Health Care Provider to refer an Indian enrollee to a network Provider. The Contractor shall comply with the following Indian Health Care Provider payment requirements of 42 C.F.R. §438.14(c) including, but not limited to:

- a. When an Indian Health Care Provider is enrolled in CHIP as a FQHC but not a participating Provider of the Contractor, it must be paid an amount equal to the amount the Contractor would pay an FQHC that is a network Provider but is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the amount the Contractor pays and what the Indian Health Care Provider FQHC would have received under fee for service.
- b. When an Indian Health Care Provider is not enrolled in CHIP as a FQHC, regardless of whether it participates in the Contractor's network or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's fee-for-service payment methodology.

The 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.

When necessary, the Contractor shall extend its Provider Network into border state areas or Subcontract for an out-of-state network to provide a comprehensive range of specialty care (e.g., for specialists not available or fully accessible within the State of Mississippi) and to serve those Members who reside within a closer proximity to health care services in border states than within Mississippi.

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, Non-compliance and Termination, of this Contract if the Contractor fails to meet Provider Network access standards.

The Contractor shall 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. The Member's financial liability for such services shall be limited to the Co-Payments amount the Member would have paid, if any, had a network Provider rendered the services. The cost of services rendered beyond the Member's financial liability shall be the Contractor's financial responsibility. Balance billing is prohibited. 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. When necessary, the Contractor may negotiate discounts with approved out-of-network Providers.

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/Substance Use Disorder Providers (routine visit)	Not to exceed twenty-one (21) calendar days
Behavioral Health/Substance Use Disorder Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health/Substance Use Disorder Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

Each network physician shall maintain hospital admitting privileges with a network hospital as required for the performance of 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.

The Contractor shall also demonstrate that there are sufficient Indian Tribe, Tribal Organization, or Urban Indian Organization (I/TIU) Providers in the network to ensure timely access to services under the Contract for Indian members who are eligible to receive services from such Providers.

3. Direct Contracting with School Clinics and School-Based Providers

The Contractor shall contract with school-based Providers and clinics unless good faith negotiations fail, and mutually agreeable contract terms cannot be reached. Any qualified school-based Provider or clinic willing to accept the Contractor's operating

terms including, but not limited to, its schedule of fees, covered expenses, and UM requirements shall be allowed to participate as a network Provider.

4. Second Opinions

The Contractor shall have policies and procedures for rendering second opinions by Providers within the network, or by non-participating Providers. 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 an Out-of-network Provider, at no cost to the Member.

5. Out-of-network Providers

The Contractor must notify and advise all Members in writing of the provisions governing the use of Out-of-network Providers.

If a Member receives medically necessary non-emergency services from an Out-of-network Provider and the Contractor has not authorized such services in advance, the Contractor is not financially liable for these services. The Contractor will not be financially responsible to Out-of-network Provider for services that are not covered under CHIP.

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 as well as expected utilization of services, given the characteristics and health care needs of the population enrolled in the Contractor.

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 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 sent to 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).

7. Family Planning

The Contractor shall demonstrate that its network includes sufficient family planning Providers to ensure timely access to covered services.

8. Accessibility Considerations

The Contractor must ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for CHIP enrollees with physical or mental disabilities.

C. **PCP Responsibilities**

The Contractor shall require PCPs to meet the following requirements:

1. PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network Provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record
2. PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by the Division, to the Contractor within one hundred eighty (180) calendar days from the date of service.
3. PCPs are responsible for contacting new Members identified in the quarterly encounter lists sent by the Contractor that indicate who has not had an encounter during the first six (6) months of Enrollment. The Contractor must require the PCP to:
 - a. Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;
 - b. Identify to the Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by the Contractor; and
 - c. Document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards.
4. Specialists as PCPs

Members with disabling conditions, chronic conditions, or 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. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in the Contractor's network.

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

D. Provider Terminations

If a 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 Network Provider and services provided by a Network Provider (which includes a specialty unit within a facility and/or a large Provider group). This notification shall occur sixty (60) calendar days prior to the effective date of the termination, if the Contractor is aware of the termination prior to this time frame.

For PCPs and hospital terminations, 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. The Division may also request Provider termination work plans and supporting documentation for other Provider types. 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. The 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. §§ 455.416 and 457.935, 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.

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

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

Failure of Contractor to substantiate cause for termination, to provide Member access to care, or other reasons adversely affecting the program, may result in the Division denial of termination.

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 monthly status updates to the work plan.

3. Termination for Cause

The Contractor must terminate any Provider (any individual or entity furnishing services to Medicaid or CHIP Members under fee-for-service or managed care arrangements) from participation in the managed care program that has been terminated for cause upon notification from the Division. For cause may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality. A termination for cause occurs when action has been taken to revoke a Provider's billing privileges, a Provider has exhausted all applicable Appeal rights or timeline for Appeal has expired, and there is no expectation on the part of the Provider or the Division that the revocation is temporary.

The Contractor must notify the Provider of its termination in writing. The notice must state the reason(s) for termination and the effective date. The Contractor must submit to the Division a copy of the Provider's notification within forty-eight (48) hours of the termination.

4. 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 that are undergoing an active course of treatment cannot use the terminated Provider. The Contractor shall receive the 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 with the Contractor, in accordance with 42 C.F.R. §438.214 and Mississippi Insurance Department 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's credentialing and recredentialing policies and procedures must meet the requirements within 42 C.F.R. §438.12 and must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor may not employ or contract with Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

The Contractor shall use credentialing and recredentialing standards set forth by NCQA and External Quality Review Organization (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 Network Providers and any Out-of-network Providers to whom Members may be referred are properly licensed in accordance with all applicable State law and regulations, are eligible to participate in CHIP, and have in effect appropriate policies of malpractice insurance as may be required by the Contractor and the Division. The Contractor must ensure that all Network Providers submit disclosure, and meet screening and enrollment requirements of 42 C.F.R. part 455, subparts B and E. This provision does not require the Network Provider to render services to fee-for-service Members. All Contractor Network Providers must submit the appropriate National Provider Identifier (NPI) numbers. Contracted nurse practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting as PCPs. The Contractor may execute Network Provider agreements pending the outcome of the process in §438.602 (b)(1) of up to one hundred and twenty (120) days, but must terminate a Network Provider immediately upon notification from the State that the Network Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without enrollment of the Provider, and notify affected enrollees.

In contracting with Providers, the Contractor will be responsible for obtaining all disclosure information from all Network Providers and Out-of-network Providers and abide by all applicable Federal regulations, including 42 C.F.R. § Part 455.104, and Subparts B and E §455.106 during the credentialing and recredentialing process.

The Contractor shall maintain a file for each Provider containing complete Provider application including a signed attestation statement, a copy of the Provider's current license issued by the State, a valid DEA or Controlled Dangerous Substances certificate; proof cover page of malpractice insurance (copy of certificates or cover pages), 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 the 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 admitting Provider from a primary source, site assessment; hospital admitting privileges or admitting plan. Proof of this verification must be maintained within each Provider file.
2. A methodology and process for recredentialing Providers every three (3) years;
3. A description of site assessment including:
 - a. The initial site assessment, prior to the completion of the initial credentialing process, of private practitioner offices and other patient care settings conducted in-person during the Provider office visit;
 - b. A site reassessment if the Provider location has changed since the previous credentialing activity;
 - c. A site reassessment of private practitioner offices and other patient care settings, conducted in-person, when a complaint has been lodged against the specific Provider. This reassessment must be completed within 60 calendar days of the complaint.
4. Procedures for disciplinary action, such as reducing, suspending, or terminating Provider privileges;
5. Procedures for practitioners to correct erroneous information;
6. Under 42 CFR 455.434(b), the requirement to submit fingerprints applies to both the "high" risk Provider and any person with a 5 percent or more direct or indirect ownership interest in the Provider, as those terms are defined in 455.101.
7. 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;
8. 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

9. 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), System of Award Management (SAM), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, National Practitioner Data Bank (NPDB), Health Integrity and Protection Databank (HIPDB), and any State listings of excluded Providers. Copies or prints of all queries shall be included in Provider credentialing files.

Receipt of all elements contained within the credentialing file prior to the credentialing and recredentialing decision with no element older than 180 days.

The Contractor maintains a Credentialing Committee:

- a. That meets at regular intervals;
 - b. Is chaired by the Contractor's Medical Director;
 - c. Membership includes a variety of participating practitioners;
 - d. Reviews credentialing files for practitioners who do not meet the established criteria;
 - e. Credentialing files that meet criteria are reviewed and approved by the Medical Director or designated physician;
 - f. Ensure the date of the Credentialing Committee decisions is included in each credentialing file.
10. Specific provisions that address acute, primary, behavioral, substance use disorders, and LTSS Providers, as appropriate.

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 within ten (10) calendar days of the Contractor's denial of a Provider credentialing or recredentialing application either for program integrity-related reasons, or the Contractor's decisions not to allow a Provider to

participate in the network.

The Contractor will load Provider information into its claims processing system within thirty (30) calendar days of credentialing approval.

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 enough Providers to ensure Member access to all Medically Necessary Services covered by CHIP. CHIP Covered services are outlined in Section 5. A, of this Contract as well as Exhibit B of this Contract.

The Contractor must ensure that all Members receiving inpatient and PRTF services are provided with a transitional care plan that includes outpatient follow-up and/or continuing treatment prior to discharge from the inpatient setting or PRTF. All new or renewal Provider agreements entered into after the effective date of this Contract must include provisions to this effect.

In all Provider agreements, the Contractor must comply with the requirements specified in 42 C.F.R. § 438.214 and Miss. Code Ann. § 83.41.409 (e). The Contractor's Provider agreements must include at least the following provisions:

1. A requirement that the Contractor must not exclude or terminate a Provider from participation in the Contractor's Provider Network due to the fact that the Provider has a practice that includes a substantial number of Members 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 Members about medically necessary treatment options violate Federal law and regulations.
3. A requirement that the Contractor cannot prohibit or restrict a Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member including; information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.
4. A requirement that the Contractor cannot prohibit or restrict a Provider acting within the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.
5. A requirement that the Contractor cannot terminate a contract or employment with a

Provider for filing a Grievance or Appeal on a Member's behalf.

6. A requirement securing cooperation with the QM and UM program standards outlined in Section 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 the Provider must submit claims within one hundred eighty (180) calendar days from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial.

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

G. Mainstreaming

The Contractor shall make all reasonable efforts to ensure that network Providers do not intentionally segregate their Members in any way from other persons receiving services.

The Contractor must investigate Complaints regarding Providers and take affirmative action so that Members are provided covered services without regard to, race, color, national origin, sex, sexual orientation, gender identity, disability, creed, religion, age, ancestry, marital status, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or 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 CHIP 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 Members, in any manner related to the receipt of any CHIP 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, national origin, sex, sexual orientation, gender identity, disability, creed, religion, age, 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. Central Time Zone, Monday through Friday). Arrangements must be made to deal with emergency Provider issues on a twenty- four (24) hours per day, seven (7) days a week basis. Provider services functions include, but are not limited to, the following:

- a. Assisting Providers with questions concerning Member eligibility status;
- b. Assisting Providers with the Contractor Prior Authorization and referral procedures, including the use of Out-of-network Providers;
- c. Assisting Providers with claims payment procedures, the coverage provided through the Contractor including supplemental coverage, and electronic submission of claims in accordance with HIPAA Electronic Data Interchange (EDI) standards.
- d. Handling Provider Complaints and Grievances;

- e. Facilitating transfer of Member Medical Records among medical Providers, as necessary;
- f. Educating Providers as to covered medical services, excluded medical services and benefit limitations; and
- g. 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.;
- h. Referring Providers to the Fraud and Abuse Hotline;
- i. Developing a process to respond to Provider inquiries regarding current Enrollment;
- j. Coordinating the administration of out-of-network services; and
- k. Assisting Provider in escalating issue to Provider Advocates.

the Contractor must develop appropriate, interactive scripts for call center staff to use when making outbound calls to Providers and to respond to Providers calls. The Contractor must develop special scripts for emergency and unusual situations, as requested by the Division. All scripts must be clear and easily understood. All scripts shall promote the use of the Contractor's web-based Provider portal. The Contractor must review the scripts annually to determine any necessary revisions. The Division reserves the right to request and review call center scripts at any time. All call center scripts must be submitted by the Contractor to the Division for review and approval thirty (30) calendar days prior to use.

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 upon request within five (5) business days. The Contractor will make recordings and associated transcripts available to the Division upon request within five (5) business days. The Contractor shall maintain the recordings and associated transcripts 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.E, Liquidated Damages, 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 Division must receive a copy of the Provider

manual for review and approval sixty (60) calendar days before implementation and/or 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 Contractor shall be expected to notify network Providers of subsequent contract clarifications and procedural changes.

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

- a. Introduction to CHIP, which explains the Contractor's organization and administrative structure;
- b. Description of the Care Management system and protocols, including Transitional Care Management;
- c. Description of the role of a PCP and Covered Services, including excluded services, Co-Payments, and benefit limitations;
- d. Emergency room utilization (appropriate and non-appropriate use of the emergency room);
- e. Listing of key contacts and telephone numbers at the Contractor;
- f. Information about how Members may access specialists, including standing referrals and specialists as PCPs;
- g. Contact follow-up responsibilities for missed appointments;
- h. Information about filing Provider disputes, Provider clinical and claims reconsiderations, clinical Peer Reviews, including contact information, i.e. telephone numbers and websites, for assistance in resolving disputes;
- i. Provider Complaint, Grievance, and Appeal information;
- j. Member Grievance and Appeal information;
- k. Billing instructions, including claims submission procedures and time frame requirements, contact information, and escalation of claims issues;
- l. Provider performance expectations, including disclosure of QM and UM criteria and processes;
- m. Provider responsibility to follow up with Members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule;

- n. A definition of “Medically Necessary” consistent with the language in this Contract;
- o. Pharmacy 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;
- p. Information about Member confidentiality requirements;
- q. Information about the process for communicating with the Contractor on limitations on accepting new Members;
- r. Information about the process for contacting the Contractor regarding assignment of a Member to an alternate PCP;
- s. Explanation of the Division’s requirements that the Contractor may not require the Provider to agree to non-exclusivity requirements nor to participate in the Contractor’s other lines of business to participate in CHIP; and
- t. 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 Well-Baby and Well-Child Care services. The Contractor shall conduct initial training within thirty (30) calendar days of placing a new Network 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 Division will work to review and approve the initial manual within forty-five (45) calendar days and any subsequent changes within fifteen (15) calendar days. The Contractor will submit reports on the trainings conducted, topics covered, the number and positions of staff completing the trainings.

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

4. Provider Communication

The Contractor shall submit all communication materials with its Providers to the Division thirty (30) calendar days prior to the planned distribution and the Division must approve these materials before they are released. Materials for approval shall include deliverables outlined in Section 10.V Deliverables in addition to Provider training

PowerPoints, website public pages that include program information and educational information, secure Provider portal and other documents at the discretion of the Division. Materials such as email blasts and templates used in performance of everyday business processes require Division review.

I. Provider Complaint, Grievance, Appeal and Independent External Review 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 Complaint, Grievance or an Appeal, and the resolution process. The information shall also advise Providers of their right to file a request for an Independent External Review with the Division of Medicaid, upon notification of a Contractor Adverse Benefit Determination, subsequent to an Appeal of the initial Contractor Adverse Benefit Determination. The Provider must exhaust all Contractor level Appeal procedures prior to requesting an impartial review with an Independent External Review..

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, regardless of whether identified as a “Complaint”, received by any employee of the Contractor orally or in writing that is of a less serious or formal nature that is resolved within one (1) calendar day of receipt. Any Complaint not resolved within one (1) calendar day of receipt shall be treated as a Grievance.			
Provider	Submit Complaint	a Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Resolve Complaint	a Within one (1) calendar day	
Grievance: An expression of dissatisfaction, regardless of whether identified as a “Grievance”, received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the enrollee’s rights regardless of whether remedial action is requested. Grievance includes an enrollee’s right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.			
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 five (5) calendar days of receipt of the Grievance	
Contractor	Resolve Grievance	a 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 an Adverse Benefit Determination related to a Member or Provider review by the Contractor of an Adverse Benefit Determination. In the case of a Member, the Adverse Benefit Determination may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member). In the case of a Provider, the Adverse Benefit Determination may include, but is not limited to, delay or non-payment for covered services			
Provider	File an Appeal	Within thirty (30) calendar days of receiving the Contractor’s notice of Adverse Benefit Determination	
Contractor	Confirm receipt of the Appeal and expected date of resolution	Within ten (10) calendar days of receipt of the Appeal	

Party	Action	Time Frame	Extensions Available
Contractor	Resolve an Appeal	<p>Within thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires</p> <p>Within three (3) calendar days after the Contractor receives the request for an Expedited Resolution of an Appeal</p>	Contractor may extend time frames by up to fourteen (14) calendar days
Independent External Review: A independent review conducted by an external party following Contractor Appeal determination. 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 Independent Reviewer. .			
Provider	File a request for an Independent External Review	Within thirty (30) calendar days of the final decision by the Contractor	

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

Contractor shall establish procedures for the resolution of administrative, payment or other disputes between Providers and the Contractor.

1. General Requirements

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 Provider Complaints, Grievances, and Appeals by Providers. Contractor must submit the Provider Complaint, Grievance, and Appeal policies and procedures to the Division for review and approval forty-five (45) calendar days before implementation. The Provider Complaint, Grievance, and Appeal policies and procedures shall be in accordance with the State's Managed Care Quality Strategy, with the modifications that are incorporated in the Contract. Contractor shall not modify the Provider Complaint, Grievance, and Appeal procedure without the prior approval of the Division, and shall provide the Division with a copy of the modification at least fifteen (15) calendar days prior to implementation.

Contractor shall review the Provider 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 Provider's behalf at any time during

Contractor's Provider 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.

2. Provider Complaints, Grievances, and Appeals

Contractor shall provide Providers as a part of the provider manual, information on how they or their representative(s) can file a Provider Grievance or an Appeal, and the resolution process.

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

J. **Reimbursement**

The Contractor shall reimburse Out-of-network Providers for which the Contractor has referred the Member to an Out-of-network Provider and out-of-area services provided to a Member in accordance with the Contractor's approved plan for out-of-network services.

The Contractor shall also pay I/T/U Providers, whether participating in the network or not, for covered managed care services provided to Indian Members who are eligible to receive services from the I/T/U either at a negotiated rate between the Contractor and the I/T/U Provider, if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the Provider were not an I/T/U Provider.

The Contractor shall be responsible for full payment for services received by Members from Out-of-network 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, which clearly and specifically states the reasons for non-payment, in a format approved by the Division and submit the policy and procedures for sampling for Explanation of Benefits for the Division approval forty-five (45) calendar days prior to use. The Contractor must send the Explanation of Benefits to Members within thirty (30) calendar days of adjudication.

The Contractor is prohibited from paying for an item or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. § 14401 *et seq.*), for roads, bridges, stadiums, or any other item or service not covered under the Child Health Plan, and for home health care services provided by an agency or organization, unless the agency provides the Contractor with a surety bond as specified in Section 1861(0)(7) of the Act.

1. Claims Payment, Denial, and Appeals

The Contractor will be responsible for processing claims. In accordance with 42 C.F.R. § 477.46, the Contractor must pay at least ninety percent (90%) of all clean claims (as defined by Miss. Code Ann. § 83-9-5) for covered services, including services provided by I/T/U Providers in the network, 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 (e.g., adjusted, corrected), 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 processed (paid or denied) by the thirtieth (30th) calendar day following the receipt of information requested, otherwise the Contractor must close (pay or deny) any other suspended claim if all requested information is not received prior to the expiration of the thirty (30) calendar day period. The Contractor shall send Providers written notice for each claim that is denied, including the reason(s) for the denial. The Contractor shall respond to Provider inquiries promptly and resolve Provider claims within a thirty (30) calendar day period for incorrectly paid or incorrectly denied claims. The determination that a pattern of inappropriate denials or delays of Provider payments exists is at the sole discretion of the Division. Failure to resolve the issue through the Corrective Action Plan may result in liquidated damages in accordance with Section 15 E, Liquidated Damages.

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 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 from Members

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

such services.

The 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 sent to 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).

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. § 438.3 (g) and §457.1201.

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.

Section 2702(a) of the PPACA prohibits Federal financial participation (FFP) payments to States for any amounts expended for providing medical assistance for health care-acquired conditions (HCACs) and other Provider-Preventable Conditions (PPCs). PPCs are hospital-acquired conditions not present on hospital admission, the wrong procedure performed on a patient, and procedures performed on a wrong patient or body part. The Contractor may not make payments for PPCs as defined by the federal regulations in accordance with 42 C.F.R. § 428.3(g). The Contractor will track PPC data and make it available to the Division upon request.

K. Provider Discrimination

Neither the Contractor, Subcontractor, nor representatives of the 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 the Division's approval prior to Provider notification. Nothing in this provision, however, shall preclude the Contractor from using a 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 Act. The Contractor is prohibited from employing or contracting a Provider that has been excluded by the Division, other state Medicaid agencies, or other state CHIP.

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/Substance Use Disorder Services.

Within thirty (30) calendar days of Contract execution, the Contractor shall provide its overall approach to Care Management specific to CHIP 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 thirty (30) calendar days prior to implementation.

1. Assignment of Risk Levels

The Contractor shall develop a Care Management program that addresses the varying and differing levels of Care Management needs for Members. 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 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, including but not limited to Members with persistent and/or preventable inpatient readmissions, serious and persistent Behavioral Health conditions, Substance Use Disorders, 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 Contractor shall conduct predictive modeling upon initial Enrollment and at least monthly to identify and evaluate Member risk levels, which must incorporate the use of pharmacy utilization data. The Contractor shall also consider Members for receiving Care Management through Provider referral, State Agency referral, and Member self-referral.

In addition, in consideration of the potential lack of complete claims or encounter data for the CHIP population prior to Enrollment with the Contractor, particularly for Members new to CHIP, the Contractor may use other analyses used to identify and

stratify Members who may be in need of Care Management services.

The Care Manager may contact potentially medium and high-risk Members and/or the Member's guardian via telephone or face-to-face interview to administer the detailed health risk assessment. 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 Member's 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 identified as potentially high- or medium-risk levels as a result of 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 (e.g., medical, Behavioral Health/Substance Use Disorder, social), documentation of recent treatment history and current medications;
- 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.

At a minimum, the Contractor shall provide Care Management services to all Members identified with the following chronic conditions: diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants.

Following the detailed health risk assessment, the Contractor shall update the risk level assignment at least annually and 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 the Division approval for other analysis or methods used to identify or re-assess Member's risk level thirty (30) calendar days prior to use by the Contractor. The Contractor shall modify its approach upon the 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 the Care Management 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, inpatient services, Urgent Care, Behavioral Health, Substance Use Disorder Services, preventive and specialty care, as needed;
- d. Assistance in developing treatment plan, conducting comprehensive needs assessment, and implementing treatment plan;
- e. Coordination of discharge planning and follow-up to care post inpatient discharge;
- f. Assistance with and coordination of re-admissions to ensure timely follow-up and documentation;
- g. Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1400 *et seq.*), 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 Department of Child Protection Services;
- h. Coordination with other Contractors;
- i. Developing, planning and assisting Members with information about community-based, free care initiatives and support groups;
- j. Responding to Member clinical care decision inquiries in a manner that promotes Member self-direction and involvement;
- k. When requested by individuals, identifying participating Providers, facilitating access and assisting with appointment scheduling when necessary;

- l. Providing information about the availability of services and access to those services;
- m. Working with Members and Providers to ensure continuity of care and care coordination; and
- n. 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. A method for actively engaging Members in need of Care Management who are unresponsive to contact attempts or disengaged from Care Management;
- c. An approach that uses pharmacy utilization data to tailor Care Management services;
- d. Systems for assuring that Members with serious, chronic, and rare disorders receive appropriate diagnostic, testing and maintenance work-ups on a timely basis;
- e. Procedures and criteria for making referrals to specialists and sub-specialists and assisting with care coordination between primary care, Behavioral Health/Substance Use Disorder and specialty Providers;
- f. Acceptance and transmittal of results of the identification and assessment of any Member with special health care needs (as defined by the Division) to or from another entity upon transition of the Member, so that those activities will not be duplicated;
- g. Procedures and criteria for maintaining treatment plans and referral services when the Member changes PCPs;
- h. Documentation of referral services and medically indicated follow-up care in each Member's Medical Record;
- i. Documentation in each Medical Record of all Urgent Care, emergency encounters and any medically indicated follow-up care; and
- j. Ensuring that when a Provider is no longer available through the Contractor, the Contractor allows Members who are receiving an ongoing course of treatment to access services from Out-of-network Providers for sixty (60) calendar days.

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/Substance Use Disorder conditions and their PCPs/Community Mental Health Centers/Private Mental Health Centers (e.g., Member education, extra clinic visits, and follow-up phone calls);
- b. Partner with Provider practices having higher medication adherence rates to identify and transfer 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 Member;
- d. Develop speaking points and triggers for making primary care, urgent and 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 and Behavioral Health/Substance Use Disorder treatment plans;
- b. Provide list of community resources (for referral) including 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 and methods or practices to minimize such barriers;
- e. Facilitate group visits to encourage self-management of various physical conditions/diagnoses such as pregnancy, diabetes and tobacco use; and Behavioral Health/Substance Use Disorder conditions/diagnoses.
- f. Communicate on a Member-by-Member basis on gaps/needs to assure Member has baseline and periodic medical evaluations from the PCP.

3. Continuity of Care

When Members disenroll from the Contractor, the Contractor is responsible for

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

Authorization and Reimbursement for Member Transition between Contractors

a. Retrospective Reviews

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

Additionally, upon receipt of notification that a Member is transferring from one (former) Contractor to a (new) Contractor, the former Contractor shall be responsible for contacting the new Contractor, the Member and the Member's Providers in order to transition existing care. A Prior Authorization (PA) shall be honored by the New Contractor for 90 days or until the recipient or Provider is contacted by the New Contractor regarding the PA. If the recipient and Provider are not contacted by the New Contractor, the existing PA shall be honored until expired.

b. Hospital Admission Prior to the Member Transition

If the Member is an inpatient in any facility at the time of transition, the entity responsible for the Member's care at the time of admission shall continue to provide coverage for the Member at that facility, including all Professional Services, until the recipient is discharged from

the facility for the current admission. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" is defined as the first five digits of a diagnosis code.

c. Outpatient Facility Services and Non-Facility Services

Effective on the Member's Transition date, the New Contractor will be responsible for outpatient services, both facility and non-outpatient hospital, ambulatory surgery centers, and renal dialysis centers.

-facility. Outp

d. Transplants

Follow up care provided on or after the Member's Transition, that is billed outside the Global Charges, will be the responsibility of the New Contractor.

e. Eligibility Issues

For a Member who loses eligibility during an inpatient stay, a Contractor is responsible for the care through discharge if the hospital is compensated under a DRG methodology, or through the day of ineligibility if the hospital is compensated under a per diem methodology.

4. Reporting

The Contractor will submit monthly and quarterly reports to the Division that include specified Care Management program data as described in Section 10, Reporting Requirements, and Exhibit G, 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.

B. Transitional Care Management

1. General Requirements

The Contractor shall maintain and operate a formalized Transitional Care Management program to support Members' transition of care when discharged from an institutional clinic or inpatient setting to include, but not limited to:

- a. Collaborating with hospital discharge planners, primary care and Behavioral Health/Substance Use Disorder staff;
- b. Ensuring appropriate home-based support and services are available and delivered in a timely manner;
- c. Implementing medication reconciliation in concert with the PCP, Behavioral Health/Substance Use Disorder Provider and network pharmacist to assure continuation of needed therapy following inpatient discharge;
- d. Ensuring appropriate follow-up appointments are made with the PCP and/or Behavioral Health/Substance Use Disorder or other specialists, as appropriate;
- e. Ensuring that the Member receives the necessary supportive equipment and supplies without undue delay;
- f. Limiting future institutional and/or inpatient setting re-admissions;
- g. Promoting the ability, confidence and change in self-management of chronic conditions; and

- h. Providing Care Management until all goals are met or Members elect not to receive services.

2. Transitional Care Management Policies and Procedures

The Contractor shall, initially, and as revised, submit to the Division for review and prior approval, Transitional Care Management policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to Member's care. The Division will work to complete the initial review within forty-five (45) calendar days and any subsequent updates within thirty (30) calendar days prior to implementation.

3. Transition of Care Team

The Contractor shall have an interdisciplinary transition of care team to design and implement the transition of care plan and provide oversight and management of all transition of care processes. The transition of care team will consist of transitional care nurses in addition to any staff necessary to enhance services for Members and provide support for their return to the home or other community setting.

4. Transition of Care Process

The Contractor will manage transition of care and continuity of care for new Members and for Members moving from an institutional clinical or inpatient setting back to the Member's home or other community setting. The Contractor's process for facilitating continuity of care will include:

- a. Identification of Members needing transition of care;
- b. Communication with entities involved in Member's transition;
- c. Making accommodations such that all community supports, including housing and other support services, are in place prior to the Member's transition and that treating Providers are fully knowledgeable and prepared to support the Member, including interface and coordination with and among social supports and medical and/or Behavioral Health/Substance Use Disorder services;
- d. Environmental adaptations, equipment and other technology the Member's needs for a successful care setting transition;
- e. Stabilization and provision of uninterrupted access to Covered Services for the Member;
- f. Summary of Member's history and current medical, Behavioral Health/Substance Use Disorder, and social needs and concerns;
- g. Assessment of Member's short-term, and long-term goals, including progress and

- revision of goals where appropriate; and
- h. Monitoring of continuity and quality of care, and services provided.

5. Transition of Care Contractor Requirements

The Contractor shall have a transition of care policy consistent with requirements of 42 C.F.R. §457.1216 and §438.62. The contractor must make its transition of care policy publicly available and provide instructions to Members and Potential Enrollees on how to access continued services upon transition. The transition of care policy must be explained to Members in the materials to Members and Potential Enrollees in accordance with §438.10.

In the event a Member entering the Contractor, either as a new Member or transferring from another Contractor, is receiving medically necessary services in addition to prenatal services the day before enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary services, without any form of prior authorization and without regard to whether such services are being provided by a Network Provider or Out-of-network Providers.

For medically necessary covered services, the Contractor shall provide continuation of such services for up to ninety (90) calendar days or until the Member may be reasonably transferred without disruption to a Network Provider, whichever is less. The Contractor may require prior authorization for continuation of services beyond thirty (30) calendar days; however, the Contractor is prohibited from denying authorization solely on the basis that the Provider is a Out-of-network Provider.

For medically necessary covered services being provided by a Network Provider, the Contractor shall provide continuation of such services from that Provider. Members who are transitioning to another Provider when a Provider currently treating their chronic or acute medical or Behavioral Health/Substance Use Disorder condition, or currently providing prenatal services has terminated participation with the Contractor, will receive continuation of coverage from such Provider for up to ninety (90) calendar days or until the Member may be reasonably transferred to another Provider without disruption of care, whichever is less.

For Members in their second or third trimester of pregnancy, the Contractor shall allow continued access to the Member's prenatal care Provider and any Provider currently treating the Members chronic, acute medical or behavioral health/substance use disorder through the postpartum period. The Contractor shall report the cases to the Division of Medicaid on the CHIP Maternity Report.

SECTION 9 – QUALITY MANAGEMENT

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

A. General Requirements

The Contractor shall support and comply with the State's Managed Care Quality Strategy. The Contractor shall also comply with all reporting requirements in formats to be determined by the Division.

The Contractor shall comply with the Mississippi CHIP 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/or CMS.

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

Table 7. Managed Care Program Quality Committees

Quality Committee	Committee Membership
Managed Care Quality Leadership Team	<ul style="list-style-type: none">• Medical Directors of each Contractor• Other Contractor Executives, as designated by the Division• Other representatives, as determined by the Division• At least two (2) network Providers from each Contractor who are actively involved in providing services to CHIP Members• Members receiving CHIP services, to be determined by the Contractor• The Division Staff

Managed Care Quality Task Force	<ul style="list-style-type: none"> • Contractors, including the Quality Managers and Health Services Managers • Quality Managers and Health Services Managers from the Behavioral Health/Substance Use Disorder subsidiary • The Division Staff
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B. Accreditation

The Division encourages the Contractor to obtain accreditation by the NCQA for MCOs. If the Contractor selects this option, it shall provide to the Division upon request 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 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 C, External Quality Review, of this Contract for additional requirements of the Contractor.

The Contractor shall address any deficiencies or contract variances identified by the EQRO expediently, on a schedule to be determined by the Division. 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 QM system and quality improvement (QI) program in compliance with 42 C.F.R. § 438.330 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 Member outcomes;

Provides for interpretation and dissemination of performance and outcome data to Network Providers and Out-of-network Providers approved for referrals for primary and specialty;
3. 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;
4. 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

5. Complies with Miss. Code Ann. § 83-41-313 *et. seq.*, 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 specific to CHIP 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 F, CHIP 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 Adverse Benefit Determinations where applicable;
and
 - d. Individual accountability for each activity.
3. Composition of the QM committee including, at a minimum, a physical and Behavioral Health/Substance Use Disorder Provider.
4. Procedures for remedial Adverse Benefit Determination 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 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 Healthcare Effectiveness Data and Information Set (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. The assessment mechanisms must be used by appropriate health care professionals.
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 Annual Program Description and other information reported to the Division, including reporting on required standards, such as network adequacy, will be published on the Division website.

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 QM and performance measurement requirements to improve the health outcomes for all Members. The Division will adopt the CHIPRA Quality Measures as its Performance Measures for CHIP. The Contractor shall meet specific performance targets, as outlined by the Division annually for each of the Performance Measures identified by the Division. The Contractor shall, on an annual basis, measure and report to the Division on its performance using the standard Performance Measures required by the Division and submit to the Division data, as specified by the Division, which enables the Division to calculate the Contractor's performance using the standard 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. The Contractor will be required to report performance on all

Performance Measures annually and quarterly in accordance with Exhibit G, Reporting Requirements.

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 also arrange for the audit of Performance Measures not included as part of HEDIS®. 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 Consumer Assessment of Healthcare Providers and Systems (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 the survey questions and methodology to the Division for review and approval 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 model within CHIP. 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, the Contractor expectations, and the 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 the Division staff. The value-based purchasing model may lead to the creation of subcommittees to current Managed Care 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. PIP topics shall be approved by the Division and 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 CHIP 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 QM 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 QM 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 Management (UM) 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 clinical practice guidelines consistent with national standards for disease and chronic illness management of Members available to Providers. These clinical practice guidelines shall be based on reasonable scientific evidence, reasonable medical evidence, reviewed annually by Network Providers who can recommend adoption of clinical practice guidelines to the Contractor, and communicated to those whose performance will be measured against them. Clinical guidelines are provided by the Contractor to physicians and other Network 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 Management

The Contractor will provide for a system of UM or 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 UM program description specific to CHIP 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 or pre-certification for inpatient hospital stays and certain surgical and diagnostic procedures, and referral that include Appeal mechanisms for Providers and Members to preclude denial of care that is appropriate and Medically Necessary;
3. Mechanisms to detect and document under-utilization as well as over utilization of all Covered Services;
4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs;

5. Availability of UM 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 Providers who request such;
8. Evaluation of new medical technologies and new application of existing technologies and criteria for use by Network Providers;
9. Annual UM 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 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, obesity, attention deficit hyperactivity disorder, and organ transplants; and
14. A comprehensive health education program that will support the Care Management programs.

At its discretion, the Contractor may elect to (but is not required to) extend Covered Services beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and supplies which are not otherwise covered. The decision to provide extended or alternative benefits shall be made on a case-by-case basis to Members who meet the UM Program's criteria. Any decision regarding the provision of extended or alternative benefits shall be made as part of the UM Program. The Contractor shall be responsible for the payment of any such benefits and shall not authorize any services specifically excluded from the State Health Plan.

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 UM criteria to Providers upon request.

O. **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.

P. **Well-Care Child Assessments and Immunizations Audit**

In conjunction with the medical audit, complete well-care assessments and immunizations claims data for the Contractor and a sample of Medical Records will be evaluated by the Division annually to determine compliance by the Contractor with the requirements of this Contract for provision of these services to Members.

The Contractor must achieve the screening rates in Table 8 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. Well-Care Child Assessments and Immunizations 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 Contractor is responsible for complying with any reports requested by the Division, and for assuring the accuracy, completeness, and timely submission of each report. The Contractor shall provide such additional data and reports as may be requested by the Division. The Division will furnish the Contractor with the appropriate reporting formats, instructions, and timetables for submission.

The Contractor shall publish screening rates in required educational and Marketing presentations to potential Members.

The Contractor may be subject to sanctions if it does not achieve the targets specified in Table 8, and provide satisfactory explanation for noncompliance to the Division, in accordance with Section 15.E, Liquidated Damages, of this Contract.

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 and any Subcontractor shall maintain detailed records evidencing all expenses incurred pursuant to this Contract; Member Enrollment status; provision of covered services; Complaints; Member grievance and Appeal records in 42 C.F.R. §438.416; base data in 42 C.F.R. §438.5(c); MLR reports in 42 C.F.R. §438.8(k); 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, including but not limited to, CMS, OIG, the Comptroller General, and their designees during the entire term of this Contract and for a period of ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit is in progress, audit findings are unresolved, or there is pending litigation that has not been completed, records shall be kept for a period of ten (10) years or until all issues are finally resolved, whichever is later. All records shall be maintained at one central office in Mississippi designated by the Contractor and approved by the Division. If the Division, CMS, OIG or Comptroller General determines that there is a reasonable possibility of fraud or similar risk, the Division, CMS, OIG or the Comptroller General may inspect, evaluate, and audit any subcontractor at any time.

All records, 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, 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 QM 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. 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

HIPAA regulations, as required by Section 16.A, Privacy/Security Compliance, of this Contract.

The Contractor shall submit to the Division copies of all reports, in full, submitted to the Mississippi Insurance Department.

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 G, 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 thirtieth (30th) 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 CHIP Member identification number, first/last name, incorrect address, and correct address, if available. In cases where a returned card may be a HIPAA violation, the Contractor must notify the Division of the potential violation within seventy-two (72) hours of discovery, in accordance with the Business Associate Agreement.

E. **Provider Services Reports**

The Contractor shall submit a monthly and 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. **Hospice Reports**

The Contractor shall provide a monthly report addressing utilization of hospice services for monitoring purposes. This report should be submitted by the fifteenth (15th) calendar day of the second month following the reporting period. The report will be prepared in accordance with the Division's format and include, at a minimum, number of Members accessing hospice services, the length time spent in hospice, total Member discharges, Member discharge status, the total number of hospice prior authorization requests, and outcomes of hospice prior authorization requests.

G. Pharmacy Lock-in Program

The Contractor shall implement a pharmacy lock-in program in order to monitor services received and reduce unnecessary or inappropriate utilization, in accordance with 42 CFR § 431.54, which restricts Members to a single pharmacy and/or other Provider type for a reasonable period of time. The Contractor's program shall include policies, procedures and criteria for establishing the need for the lock-in, based upon whether the Member has utilized CHIP services at a frequency or amount that is not medically necessary. These policies must be prior approved by the Division of Medicaid, Office of Program Integrity and must include the following components to the program:

1. Members must be notified and given the opportunity for an Independent External Review (in accordance with applicable policies and procedures established by the Division) before imposing the restrictions.
2. The Contractor ensures that the Member has reasonable access (taking into account geographic location and reasonable travel time) to services of adequate quality.
3. The restrictions do not apply to emergency services furnished to the Member. For pharmacy, a seventy-two (72)-hour emergency supply of medication at pharmacies other than the designated lock-in pharmacy shall be permitted to assure the provision of the necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication.
4. Members must be permitted to choose or change Providers for good cause. Good cause is defined as:
 - a. Death, retirement, or closing of the specified Provider,
 - b. Change in geographical location of the Member or Provider,
 - c. Provider discontinues participation in the CHIP Program, or
 - d. Provider is terminated from participation in the Medicaid program or CHIP of any other state.
5. Care management and education reinforcement of appropriate medication/Provider use shall be provided. A plan for an education program for Members shall be developed and submitted for review and approval.
6. The continued need for lock-in shall be re-evaluated at the end of the lock-in period by the Contractor for each Member in the program.
7. When finalizing Member lock-in decisions, the Contractor shall take into consideration the Member's prior lock-in experiences with the Medicaid Fee-For-Service Program and those of other CHIP-participating Contractors, utilizing lock-in data made available by the Division. The Contractor may be required to lock-in Members at the request of the Division.

The Contractor shall submit a monthly report providing information on the Pharmacy Lock-In Program in a manner and format established by the Division.

H. Medical Records

The Contractor shall make all reasonable efforts to 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 the Division policies and procedures.

As described in 42 C.F.R. Part 456, Subparts C and D, Medical Record content must include, at a minimum for hospitals and mental hospitals:

- a. Identification of the Member;
- b. Physician name;
- c. Date of admission and dates of application for and authorization of CHIP benefits if application is made after admission; the plan of care;
- d. Initial and subsequent continued stay review dates;
- e. Reasons and plan for continued stay if applicable;
- f. Other supporting material the committee believes appropriate to include. For non-mental hospitals only;
- g. Date of operating room reservation; and
- h. Justification of emergency admission if applicable.

Medical records shall be accessible and made available by Providers providing services to Members enrolled with the contractor, and to the Division for purposes of Medical Record review. The Contractor shall follow applicable policies and procedures in accordance with Division Administrative Code. For any services billed by a provider for which the medical record cannot be provided to support the services rendered, the Contractor is instructed to recoup the reimbursement paid to the provider for those services.

I. Financial Reports

The Contractor shall file with the Division, within seven (7) calendar days after issuance, a true, correct, and complete copy of any report or notice issued in connection with a financial examination conducted by or on behalf of the Mississippi Insurance Department

The Contractor shall submit to the Division a copy of all quarterly and annual filings submitted to the Mississippi Insurance Department. A copy of such filing shall be submitted to the Division on the same day on which it is submitted to the Mississippi Insurance Department. Any revisions to a quarterly and/or annual Mississippi Insurance Department financial statement shall be submitted to the Division on the same day on which it is submitted to the Mississippi Insurance Department.

Throughout the duration of the Contract term, the Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial

reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor shall enhance or update it upon request. Throughout the term of the Contract, the Contractor must notify the Division prior to making any changes to its basis of accounting.

The Mississippi Insurance Department regulates the financial stability of all appropriately licensed Contractors in Mississippi. The Contractor agrees to comply with all Mississippi Insurance Department standards.

The Contractor shall file with the Division, within seven (7) calendar days of request, other financial reporting as required for the Capitation Payment development process.

J. 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. The Contractor must maintain documentation supporting claims that were denied or recovered during their coordination of benefits (COB) process and be able to provide this documentation upon audit request.

K. Third Party Liability Reporting

The Contractor shall provide a monthly report of CHIP Third Party Subrogation leads 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 fifth (5th) business day of the second month following the reporting period. The Division's third party unit will review the monthly report and inform the Contractor whether or not the Division 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.

The Contractor shall submit monthly the CHIP Third Party Resources report containing a list of all CHIP recipients that have been identified as having a potential policy with full health coverage. If the full health coverage policy is valid, the Office of Eligibility will begin the disqualification process to remove the recipient from the CHIP program and notify the Contractor. The report should include, at a minimum, the Member's name, Medicaid identification number, carrier name, date of birth, policy holder, policy number and policy eligibility period.

The Contractor must report denials on all claim types including those from their delegated vendors/subcontractors. The Contractor shall submit monthly to the Office of Recovery a report showing the total amount of all claims that were denied (cost avoided) due to the existence of having an allowed TPL policy (dental or vision) or full health coverages policies on file. Cost avoidance is the method of denying claims (avoiding payment) when other insurance resources are liable for payment.

The Contractor must report recoveries on all claim types including those from their delegated vendors/subcontractors. This also includes all retroactive coverages that are identified after

the claim has already been processed, but before the timely filing of the coverage has lapsed. The Contractor shall submit monthly to the Office of Recovery a report showing the total amount of all monies recovered from an allowed TPL policy (dental or vision) and full health coverages policies identified after Contractor had initially paid the claim as primary. The Contractor must maintain documentation supporting claims that were denied by other carriers during their coordination of benefits (COB) process and be able to provide this documentation upon audit request.

All recovery amounts realized by the Contractor and their delegated vendors/subcontractors must be included within the monthly recovery reports submitted to DOM. If recoveries are not reported, Contractor must provide an explanation as to why these recoveries were not reported to DOM.

L. 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 quarterly and by the fifth (5th) business day of the second month following the reporting period, a mutually agreed upon summary report of all 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 monthly and by the fifth (5th) business day of the second month following the reporting period, 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. Member Complaint and Grievance categories identified shall be organized or grouped by the following general guidelines:
 - a. Access to services/Providers;
 - b. Provider care and treatment;
 - c. Contractor customer service;
 - d. UM;
 - e. Marketing;
 - f. Payment and reimbursement issues; and
 - g. Administrative issues.
2. Appeal categories identified shall be organized or grouped by the following general guidelines:
 - a. Contractor administrative issues; and

- b. 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 CHIP 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 Complaint, Grievances, or Appeals or its system for tracking Complaint, Grievances and Appeals required to be filed with the Mississippi Insurance Department.

M. Provider 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 Provider Complaints, Grievances, and Appeals. The Contractor shall submit to the Division by the fifth (5th) business day of the second month following the reporting period, a mutually agreed upon summary report of all Provider 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 fifth(5th) business day of the second month following the reporting period a detailed log of all Provider Complaints, Grievances and Appeals made under this Contract.

1. Provider Grievance and Complaint categories identified shall be organized or grouped by the following general guidelines:
- a. Access to services/Providers;

- b. Provider care and treatment;
 - c. Contractor customer service;
 - d. Payment and reimbursement issues; and
 - e. Administrative issues.
2. Provider Appeal categories identified shall be organized or grouped by the following general guidelines:
- a. Contractor administrative issues; and
 - b. Benefit denial or limitation.
3. The log shall contain the following information for each Provider Complaint, Grievance, or Appeal:
- a. The date of the communication;
 - b. The Provider's Mississippi CHIP identification number and/or NPI number;
 - c. Whether the Provider Complaint, Grievance or Appeal was written or verbal;
 - d. Indication of whether the dissatisfaction was a Provider Complaint, Grievance or Appeal;
 - e. The category, specified in Subsection 1, of each inquiry;
 - f. A description of subcategories or specific reason codes for each Provider Complaint, Grievance and Appeal;
 - g. The resolution (detailed information about how the Provider 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 Provider Complaints, Grievances, or Appeals or its system for tracking Provider Complaints, Grievances, and Appeals required to be filed with the Mississippi Insurance Department. The Contractor shall document Provider Complaints, Grievances, and Appeals that proceed through multiple review steps in its tracking systems such that the entire Provider Complaints, Grievance, and Appeal process is easily identified. The Contractor must maintain Provider Complaints, Grievance, and Appeal records in a manner that is reasonably clear and accessible to the Division for review and shall be provided to the Division for inspection upon request. The Contractor shall maintain records for the length of the Contract and transferred to the Division upon termination of the Contract.

N. Confidentiality of Information

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 the 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 2, 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.

This requirement of confidentiality survives the term of the Contract between the Division and the Contractor.

See also Section 4.15.2, Release of Public Information, and Section 4.15.4, Transparency, of the Mississippi CHIP RFQ for additional requirements.

O. Access to Records

Pursuant to the requirements of Title XXI, Section 2107(b)(3) of the Act, 42 C.F.R. § 434.6(a)(5), § 457.720, and § 457.950, 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 the 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. § 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 the 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 HHS, for the purpose of audits, investigations, evaluations or other statutory functions of the Inspector General of HHS, 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 fifteen thousand dollars and zero cents (\$15,000.00) 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.

P. 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

CHIP eligibility. The Contractor must collect data on Member and Provider characteristics (i.e., tracking of appointments kept and not kept, place of service, Provider type), and make all collected data available to the Division, to CMS, to the Mississippi Insurance Department, and to any other oversight agency of the Division.

The Contractor shall comply with Section 6504(a) of the PPACA, which requires that the State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.

The Contractor shall ensure that all data received from Providers is accurate and complete by verifying the accuracy and timeliness of reported data, including from Network Providers the Contractor is compensating on the basis of capitation payments; screening the data for completeness, logic, and consistency; and collecting data from Providers in standardized formats to the extent feasible and appropriate, including protected identifiable information and health information through secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

The Contractor shall work with the Division and their Fiscal Agent to define a mutual statement of work and schedule to implement software and hardware routing solutions required for the successful delivery of all available clinical data (including, but not limited to: Laboratory reports, Radiology reports, Admission/Discharge/Transfer data, Consolidated-Clinical Data Architecture, and Pathology reports from the Contractor's Electronic Health Record system of record to the Division in either HL7 version(s) 2.3.1 or 2.5.1 or in Consolidated-Clinical Document Architecture (C-CDA) format.

The Contractor shall make all data collected in accordance with 42 C.F.R. §438.242 available to the Division and upon request CMS. The Contractor shall provide to the Division all clinical data that is captured by Providers and any additional clinical data as identified by the Division. Clinical data, includes but is not limited to diagnoses, procedures, medications, immunizations, allergies, smoking status, BMI, vitals, visit notes, radiology orders, tests ordered and results received for general labs and pathology labs. Clinical data shall be provided to the Division using the clinical data exchange standards of C-CDA and/or HL7 2.5. The Division is very focused on the clinical data exchange project between the Contractor and the Division and fully expects it to continue to move forward. At this time, the information available through MS HIN is very different than the clinical information that will be exchanged between the Contractor and the Division. The Division believes that the data that MS HIN provides can bring value to the Contractor and therefore encourages participation in MS HIN. However, Division connectivity with MS HIN is not a financial priority currently; thus, the Contractor connectivity at this time would be a Contractor business decision.

This participation shall include sharing clinical data with the HIE to support the goal of sharing clinical data with Providers throughout the state as necessary to improve the quality, timeliness and cost of care.

The Population Health Management program will address, at a minimum, the elements

identified in this subsection. The Division must review and approve the Population Health Management program, including policies and procedures, prior to implementation by the Contractor, and semi-annually thereafter.

1. Data Analytics

The Division will support the Contractor in achieving program goals by providing a common data platform. The use of a common data platform will allow Providers to access all Member health information and analytics via a single sign-on process. The Contractor may choose to leverage their own technologies to support Member data analysis. However, the Contractor will be financially responsible for ensuring that such technology may be accessed through the Division's single sign-on process.

2. Reducing Health Disparities

The Contractor will develop and implement strategies to address disparities in health outcomes and access to care based on factors such as geographic location, race, ethnicity, income level, age, gender, language barriers and physical disabilities. While each Contractor will provide coverage across the State, strategies implemented here must reflect significant regional variation in these factors.

The Contractor will also develop protocols for providing population health management services in alternative and community-based settings, which may include providing services in:

- a. Homeless shelters, group homes, or other residential placements;
- b. Public or non-profit community organization facilities; and
- c. The Member's home, school, or place of employment, as applicable and allowed by State law.

3. Community Partnerships

The Contractor will seek out and enter into agreements with community-based entities to address social determinants of health in each region of the State. Such agreements will be designed to support the implementation of coordinated, culturally competent care strategies and will include, but are not limited to, protocols for:

- a. Data sharing and data protection;
- b. Implementing health promotion and disease prevention initiatives;
- c. Coordinating services delivery with the Member's Health Home;
- d. Tracking Member outcomes and measuring success.

4. Health Education & Promotion

The Contractor will employ creative and innovative educational programs that are designed to raise Member awareness, enhance Member participation in self-care, and promote ongoing engagement. Programs must focus on helping Members identify and understand common risk factors and evidence-based strategies that they can employ to reduce their own health risk. Such programs may include those designed by the Contractor as well as coordinated referrals to programs operated by local public health or community-based organizations. Program design must consider the appropriate use of multiple information sources, which may include social media and other web-based initiatives, as well as telephonic and paper-based resources and in-person events.

5. Health Education & Promotion

To effectively address the specific health needs of enrolled Members, the Contractor must employ a comprehensive risk assessment and stratification methodology. The Contractor will conduct a health risk assessment at the time of enrollment and update at regular intervals thereafter based on the Member's initial risk level. The risk assessment must include both qualitative data reported by the Member and available quantitative data to support appropriate stratification. The risk assessment must consider socioeconomic and environmental risk factors that may impact the Member's health outcomes, as well as the Member's health behaviors and readiness to change.

Based on the health risk assessment, the Contractor will stratify their Members according to their identified risk level. A minimum of four risk levels should be employed: low, moderate, rising, and high risk. The Contractor will design and execute risk management strategies that are tailored to Member needs at each risk level and communicate such strategies with Network Providers. Regardless of risk level, Contractor will provide all Members with resources aimed to maintain their health, improve health care decision-making skills, and increase adoption of healthy behaviors.

6. Care Management

The Contractor will provide Care Management using a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. The Contractor will develop and implement a Care Management system to ensure and promote:

- a. Ongoing, culturally relevant support for Members to achieve personal health goals;

- b. Timely access to and delivery of health care and services required by Members;
- c. Continuity of Members' care;
- d. Coordination and integration of Members' care in accordance with 42 C.F.R. § 438.208, including physical and behavioral health/substance use disorder services; and
- e. Coordination with appropriate resources to reduce socioeconomic disparities, including housing, employment, and nutrition programs.

All Members will have access to Care Management at levels of intensity appropriate to their identified risk, which will include services and supports to promote evidence-based health education and disease prevention, continuity of care, transition of care and discharge planning. Care Management programs must meet applicable National Committee for Quality Assurance (NCQA) and/or Utilization Review Accreditation Commission (URAC) accreditation standards. The Contractor shall implement transition of care policies in accordance with 42 C.F.R. § 438.62.

The Contractor will participate as a partner with Providers and Members in arranging for the delivery of healthcare services that improve health status in a cost-effective way. The Division expects the Contractor to connect all Members to a Health Home. Care management strategies employed by the Contractor should support this model of care.

7. Targeted Interventions

The Contractor will offer evidence-based interventions to address subpopulations experiencing unique health risks. Subpopulations may include Members with disabilities, specific chronic conditions or comorbidities, those with specific environmental risk factors or those with a history of high or inappropriate service utilization.

The Contractor shall coordinate with the Mississippi 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) Program. 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 Management will support all of the Members health care needs.

8. Reporting

The Contractor must report to the Division and Network Primary Care Providers, at intervals designated by the Division, on the efficacy of its Population Health

Management program. The report will be designed collaboratively by the Division and the Contractor and will include, but is not limited to, measures to identify changes in:

- a. Health disparities among subpopulations;
- b. Targeted health outcomes;
- c. Member participation in health promotion and disease prevention initiatives;
- d. Percent of Members in each risk stratification level; and
- e. Member utilization of inpatient and emergency department services.

Q. Encounter Data

In accordance with C.F.R. § 438.818, 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 at least monthly following the month in which the claims were adjudicated (paid, amended or denied status). Encounter Data consists of a separate record each time a Member has an Encounter with a health care Provider including Member Encounter Records reflecting zero-dollar (\$0) amount as well as Member Encounter Records where the Contractor has a capitation arrangement with the Provider. For any services which the Contractor has entered into capitation reimbursement arrangement with Providers, the Contractor shall comply with all Member Encounter Data submission requirements in this section. The Contractor shall require timely submissions from its Providers as a condition of the capitation payment. A service rendered under this Agreement is considered an Encounter regardless of whether 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. Adjustments necessitated by administrative payments or recoupments, program integrity recoupments, lump sum payments and payment errors, processed during that payment cycle are not considered duplicate records.

The Contractor is required to submit encounter data directly to the Division's Fiscal Agent using established protocols. All Member Encounter Data must be submitted to the Division's Agent by the Contractor. The Division will not accept any Member Encounter Data submissions or correspondence directly from any Subcontractors, and the Division will not forward any electronic media reports or correspondence directly to a Subcontractor. The Contractor will be required to receive all electronic files and hardcopy material from the Division, or its Agent, and distribute them within its organization or to its Subcontractors as needed.

The Contractor must maintain appropriate systems and mechanisms to obtain all necessary data from its Providers 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 Division may impose liquidated damages or other available remedies under Section 15, Non-Compliance and Termination, of this Contract for non-compliance.

1. Data Format

The Contractor must submit Encounter Data to the Division's Fiscal Agent using established protocols. The Contractor must provide Member Encounter Data in the format required by the Division, necessary for capitation rate development, program oversight, and reporting requirements, including inpatient claims and encounter payment simulations. The Contractor shall be able to receive, maintain and utilize data extracts from the Division and its contractors, e.g., pharmacy data from the Division or its PBM.

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

The Contractor's system must conform to the following HIPAA-compliant standards for information exchange transactions. Batch transaction types include, but not limited to the following:

- a. ASC X12N 837P Professional Claim/Encounter Transaction;
- b. ASC X12N 837I Institutional Claim/Encounter Transaction;
- c. ASC X12N 837D Dental Claim/Encounter Transaction;;
- d. NCPDP Version D.0 Pharmacy;
- e. ASC X12N 277 Claims Status Response; and
- f. ASC X12N 835 Claims Payment Remittance Advise Transaction.

2. Provider Claims

The Contractor shall encourage Providers to submit claims as soon as possible after the dates of service. Providers shall have one hundred eighty (180) calendar days to submit claims from the date of service. For the purpose of timely filing, the "Through" date shall be used for determining claims filing. Claims filed within the appropriate time frame but denied may be resubmitted 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.E, Liquidated Damages, of this Contract for non-compliance with these requirements.

3. Encounter Submissions

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

The level of detail associated with encounters from Providers with whom the Contractor has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the Contractor received and settled a fee-for-service claim. The Contractor must collect and maintain sufficient Member Encounter Data to identify the Provider who delivers any item(s) or service(s) to Members. The Provider's National Provider Identifier (NPI) shall be used when submitting required Member Encounter Data. Member encounter data elements must include all of the data the Division is required to report to CMS under 42 C.F.R. §438.818 included but not limited to:

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

The Contractor must submit all Member Encounter Data processed by the Contractor and any Subcontractor no later than the sixtieth (60th) calendar day after the date of adjudication and include all Member Encounter Data, Member encounter data adjustments, encounters reflecting a zero-dollar amount (\$0.00), encounters reflecting claim voids, encounter claims reflecting denied claims and encounters in which the Contractor has a capitation arrangement with the Provider. The files shall contain settled claims and claim adjustments, including but not limited to adjustments necessitated by administrative payments or recoupments, program integrity recoupments, lump sum payments and payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from Providers with whom the Contractor has a capitation arrangement. Submissions shall be comprised of encounter records or adjustments to previously submitted records, which the Contractor has received and processed from Provider encounter or claim records of all contracted services rendered to the Member in the current or preceding months.

The Contractor shall submit Member Encounter Data according to standards and formats as defined by the Division, including those referenced in the companion Guide(s), complying with standard code sets and maintaining integrity with all reference data sources including Provider and Member data. All Member Encounter Data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the Contractor for immediate correction. When the Division or its Agent rejects a file of encounter claims, the resubmittals of rejected files must be resubmitted with all of the required data elements in the correct format by the Contractor within fourteen (14) calendar days from the date the Contractor received the rejected file. The Division may impose liquidated damages or other available remedies under Section 15, Non-Compliance and Termination, of this Contract for non-compliance with these requirements.

Encounter records sent to the Division's Fiscal Agent by the Contractor are considered acceptable when they pass all the Division's Fiscal Agent's edits. The Contractor must make an adjustment to encounter claims when the Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed. If the Division or its Agent discovers errors or a conflict with a previously adjudicated encounter claim the Contractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by the Division. The Division may impose liquidated damages or other available remedies under Section 15, Non-Compliance and Termination, of this Contract for non-compliance with these requirements.

Encounter records that deny due to the Division's Fiscal Agent's edits are returned to the Contractor and the Contractor must make the requested corrections. The Contractor shall resubmit denied Encounter records within the time frame referenced above.

The Contractor shall correct and resubmit 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 Fiscal Agent.

The Contractor shall ensure that the payment information on the Subcontractors' Member Encounter Data reflect the date and the amount paid to the Provider by the Subcontractor. 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.E, Liquidated Damages, 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 to the Contractor by the Division in advance of operational go-live date.

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 Fiscal 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. The Division will work to review and approve the Data Completeness Plan within thirty (30) calendar days. 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. Accuracy of Data

The Contractor will assist the Division in reconciliation of Cash disbursement check amount totals to Contractor Paid Amount totals for submitted claims. The Contractor shall submit at least ninety-eight percent (98%) of all Member Encounter Data in a valid format, which will be deemed valid by the Division, including those of Subcontractors or delegated vendors as provided for in this Section, both for the original and any adjustment or void. The Division or its Agent will validate Member Encounter Data submissions according to the Cash Disbursement Journal of the Contractor and any of its applicable Subcontractors. The measurement report for

this validation shall be the Encounter Claims to Cash Disbursements Report for the Twenty-four (24) month period ending with the state's fiscal year end period for the month of June of the current year. This measurement period shall apply to Encounter Claims of the Contractor and all measurement period shall apply to Encounter Claims of the Contractor and all Subcontractors measured by the Entire Plan and each Service category. If the Contractor fails to submit complete Member Encounter Data, as measured by a comparison of encounters to cash disbursements, Contractor may be subject to liquidated damages or other available remedies as outlined in Section 15, Non-compliance and Termination, of this Contract.

The data accuracy requirement also consists of assurance that the Encounter Data accurately reflects the information contained within the Contractor's or Subcontractor's Claims Systems, while the Claims System data should be an accurate representation of the information contained within the Medical Record(s) that substantiates the clinical service(s) provided. It is the Division's expectation that the individual data elements captured at each transactional state of this process cycle are accurately transmitted and reconcilable with each other. The Division or its agent may, at its discretion, determine to periodically test and evaluate the accuracy of the encounter data through sampling or through a more comprehensive EQR Protocol 4 review. If the Contractor fails to maintain accurate Encounter Data, as measured by a comparison of encounter to claims data and/or claims data to medical records, Contractor may be subject to liquidated damages or other available remedies as outlined in Section 16, Default and Termination, of this Contract.

Ninety-eight percent (98%) of the records in the Contractor's encounter batch submission must pass X12 EDI compliance edits and the Mississippi Medicaid MMIS threshold and repairable compliance edits. The X12 EDI compliance edits are established through Strategic National Implementation Process (SNIP) levels one (1) through four (4). MMIS threshold and repairable edits that report exceptions are set forth in the Companion Guide

7. 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.

8. 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 CHIP under this Contract. 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.E, Liquidated Damages, of this Contract for any encounter data not received monthly or in cases that the data does not meet the Division's requirements.

R. 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, under penalty of perjury, 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.

S. Claims Processing and Information Retrieval Systems

The Contractor's claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements identified in this Contract. The Contractor's information retrieval systems must have the capability to accept claims history data from the Division or its Agent.

T. 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 CHIP Fraud and Abuse for Referrals and Reporting to the Division of Medicaid, Office of Program Integrity (PI). The Office of Program Integrity will oversee all Fraud, Waste and Abuse activities conducted by the Contractor as outlined in 42 C.F.R. § 438.608 and Part 455.

All retrospective and prepayment reviews must be pre-approved by the Mississippi Division of Medicaid, Office of Program Integrity. The Contractor must submit a request to retrospectively audit or place Providers on prepayment review by submitting weekly reports to the Office of Program Integrity. If Division approves the investigation, the Contractor will be responsible for collecting the Overpayment for any Provider audited. If it is determined that the Division, Office of Program Integrity will conduct the investigation, the Division will be responsible for collecting the Overpayments of Providers audited. The Contractor will be required to report to the Office of Program Integrity twice a year all Overpayments recovered from Providers. This information, along with Office of Program Integrity Overpayments, will be reported to the entity that is responsible for the rate setting.

The Contractor must implement and maintain procedures that are designed to detect and prevent fraud, waste and abuse. The procedures must include the following:

1. Provision for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud to the State.
2. Provision for prompt notification to the State when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including all of the following:
 - a. Changes in the Member's residence;
 - b. The death of a Member.
3. Provision for notification to the State when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the managed care program, including the termination of the Provider agreement with the Contractor.
4. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Members and the application of such verification processes on a regular basis.
5. In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the Contract of at least \$5,000,000, provision for written policies for all employees of the entity, and of any Contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a) (68) of the Act, including information about rights of employees to be protected as whistleblowers.
6. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.
7. Provision for the Contractor's suspension of payments to a Network Provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23.

U. Internal Contractor Reporting

The Contractor is responsible for reporting all suspected or confirmed instances of internal Fraud and Abuse relating to the provision of and payment for Medicaid services including, but not limited to Fraud and Abuse acts related to the Contract and/or the Division of Medicaid that is other than Provider and Member Fraud and Abuse (e.g. internal to the health plan—employees/management, Subcontractors, vendors, delegated entities). This report shall include at a minimum:

1. The date reported (“Date reported” is the date the report was submitted to the Office of Coordinated Care);
2. The name of the Contractor reporting;
3. The name of the individual or entity;
4. The entity’s tax identification number;
5. A description of the acts allegedly involving suspected Fraud or Abuse:
 - a. Source of Complaint/detection tool utilized;
 - b. Nature of Complaint;
 - c. If applicable, case closed due to:
 - i. Corrective action completed by Provider;
 - ii. Provider voluntarily left network;
 - iii. Provider involuntarily terminated by Contractor;
 - iv. Other (specify).
6. Potential exposure/loss identified;
7. If known, actual exposure/loss identified;
8. If applicable, exposure/loss collected or recouped from individual or entity by the Contractor.

In accordance with the PPACA and the Mississippi Administrative Code Section 23, Part 305, the Contractor shall report Overpayments made by the Division of Medicaid to the Contractor as well as Overpayments made by the Contractor to a Provider.

V. 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.

W. Deliverables

The Contractor must obtain the 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 QM 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. In the absence of a specific time frame listed for a Deliverable within the Contract, the Division will work to review and approve a Deliverable within forty-five (45) calendar days from the date of submission.

The Division may impose penalties under Section 15.E, Liquidated Damages, of this Contract if the Contractor fails to submit Deliverables for approval based on the requirements set forth in this Contract.

X. 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.

Y. Cost or Pricing Data

If the Division determines that any price, including profit or fee, negotiated in connection with this Contract was increased because the Contractor furnished incomplete or inaccurate cost or pricing data not current as certified in the Contractor's certification of current cost or pricing data, then such price or cost shall be reduced accordingly and this Contract shall be modified in writing and acknowledged by the Contractor to reflect such reduction.

Z. Drug Rebate Data

The Contractor must report to the Division, on a timely and periodic basis specified by the Secretary of HHS, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to

Members for which The Contractor is responsible for coverage (other than outpatient drugs) and other data as the Secretary determines necessary.

The Contractor must report any rebates collected to the Division in a format and frequency determined by the Division.

AA. CHIP Maternity Reporting

When the Contractor becomes aware that a CHIP Member is possibly pregnant, a special review must be completed to verify pregnancy/due date. The Contractor shall submit a report with the following required information to the Division's Office of Eligibility:

- a. Member's County of residence
- b. Member Name
- c. Member ID
- d. Date of Claim
- e. Case Name
- f. Case Number

The Contractor shall include the required information in the report when the Contractor becomes aware of the pregnancy through communications with the Member or through the Contractor's claims system, whichever is first. The Contractor shall submit the preceding month's report to the Division's Office of Eligibility every month on the first workday of the current month. The Division's Office of Eligibility will process the submission, verify the Member's pregnancy, and if applicable, transition the Member from CHIP to Medicaid Category of Eligibility (COE) 088 for the duration of pregnancy and post-partum period.

If an Adverse Benefit Determination is taken by the end of the current month, CHIP will terminate at the end of the current month and the pregnant minor will move to Medicaid COE-088 the following month. The head of household is issued a notice which contains information about the child's eligibility.

If there are months remaining in CHIP at the end of the post-partum period, the child will return to CHIP and an eligibility review completed when due. If the pregnant minor's review comes due while she is on COE-088, the review will be completed. If the child is eligible for full Medicaid, an Adverse Benefit Determination can be taken immediately to change the child from COE-088 to the appropriate MAGI coverage group for a child under age 19. If the child continues to be CHIP-eligible at review, the new 12-month eligibility period is effective at the end of the post-partum period.

SECTION 11 – Program Integrity

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. The Contractor shall comply with all federal and state requirements regarding Fraud, waste, and Abuse including but not limited to 42 C.F.R. § 455, Section 1902 (a) (68) of the Social Security Act and 42 C.F.R. § 438.608.

The Contractor shall complete a minimum of three (3) Division acceptable Provider-site audits per Contract year. The Division, at its sole discretion, may waive the minimum requirement. Additional Provider on-site audits may be conducted by mutual agreement of the Division and the Contractor.

At least one full-time investigator designated for the state of Mississippi and a staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 11 of this Contract. The investigator will have full knowledge of Provider investigations related to the CHIP program and will be the key staff handling day-to-day Provider investigation related inquiries from the Division, Office of Program Integrity.

The Mississippi Code of 1972, Title 43 Chapter 13 as amended, describes the penalties related to fraud in the Medical Assistance Program. Suspected Fraud/Abuse regarding a Provider or Member should be addressed to the Division of Medicaid, Office of Program Integrity. The Division of Medicaid Office, of Program Integrity should be notified in writing within thirty (30) days of the discovery of any Overpayments made by Medicaid caused by billing errors, system errors, human error, etc.

The Division of Medicaid shall conduct investigations related to suspected Provider Fraud, Waste, and Abuse cases and reserves the right to pursue and retain recoveries for any and all types of claims which the Contractor does not have an active investigation.

1. The Contractor shall be subject to onsite reviews; and comply with requests from the Division of Medicaid to supply documentation and records;
2. The Contractor shall not knowingly be owned by, hire or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State, in accordance with 42 C.F.R. §438.610.
3. The Contractor and the Office of Program Integrity shall meet quarterly or more frequently as needed, to discuss areas of interest for past, current, and future investigations and to improve the effectiveness of Fraud, Waste, and Abuse oversight activities.
4. The Division of Medicaid shall establish Performance Measures to monitor the Contractor's compliance with the Program Integrity requirements set forth in this Contract.

The Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a Provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

1. The improperly paid funds have already been recovered by the state of Mississippi, either by the Division directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or
2. The improperly paid funds have already been recovered by the State's RAC; or
3. When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the state of Mississippi, are the subject of pending Federal or State litigation or investigation, or are being audited by the Mississippi RAC.

This prohibition as described above shall be limited to a specific Provider(s), for specific dates, and for specific issues, services or claims. The Contractor shall confer with the Division of Medicaid, Office of Program Integrity before initiating any recoupment or withhold of any program integrity related funds to ensure that the recovery recoupment or withhold is permissible. In the event that the Contractor obtains funds in cases where recovery recoupment or withhold is prohibited under this section, the Contractor will return the funds to the Division.

In accordance with 42 C.F.R. §438.604, the Contractor must submit to the State the following data:

1. Member Encounter Data in the form and manner described in §438.818.
2. Data on the basis of which the State certifies the actuarial soundness of capitation rates to the Contractor under §438.4 and, including base data described in §438.5 (c) that is generated by the Contractor.
3. Data on the basis of which the State determines the compliance of the Contractor with the medical loss ratio requirement described in § 438.8.
4. Data on the basis of which the State determines that the Contractor has made adequate provision against the risk of insolvency as required under § 438.116.
5. Documentation described in § 438.207(b) on which the State bases its certification that the Contractor has complied with the State's requirements for availability and accessibility of services, including the adequacy of the Provider network, as set forth in § 438.206.
6. Information on ownership and control described in § 455.104 of this chapter from the Contractor and Subcontractors as governed by § 438.230.

7. The annual report of overpayment recoveries as required in § 438.608(d)(3).
8. In addition to the data, documentation, or information listed above, the Contractor must submit any other data, documentation, or information relating to the performance of the entity's obligations under this part required by the State or the Secretary.

The data submitted will be posted to the State's website as required by §438.10(c)(3). The data, documentation, or information submitted must be certified by either the Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. The certification provided must attest that, based on best information, knowledge, and belief, the data, documentation, and information is accurate, complete and truthful and be submitted concurrently with the submission of the data, documentation, or information.

B. Fraud and Abuse Compliance Plan

The Contractor must submit its compliance plan, including Fraud and Abuse policies and procedures to the Office of Program Integrity for written approval within thirty (30) days before those plans and procedures are implemented. Failure to implement an approved plan within sixty (60) days may result in liquidated damages. The Office of Program Integrity may reassess the implementation of the Fraud and Abuse compliance plan every sixty (60) days until Program Integrity deems the plan to be in compliance.

In accordance with 42 C.F.R. § 438.608, the Fraud and Abuse compliance plan shall comply with the Division's policies and procedures for Fraud and Abuse and must include at a minimum all of the following elements:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.
2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the Board of Directors.
3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract.
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the Contract.

5. Effective lines of communication between the Compliance Officer and the organization's employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.
8. Assistance to the Division in any investigation or prosecution of Fraud by providing the following:
 - a. Access to and free copies of computerized data stored by the Contractor;
 - b. Direct computer access to computerized data stored by the Contractor that is supplied without charge and in the form requested by the Division; and
 - c. Access to any information possessed or maintained by any Provider of service(s) under the Medicaid State Plan to which the Division and the Contractor are authorized to access.

If the Contractor identifies that a Member or Provider is committing Fraud and Abuse, the Contractor may terminate the Provider and/or 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

Exhibit A, Capitation Rates, of this Contract includes the capitation rates per Member per month.

1. Monthly Payments

On or before the Tenth (10th) business 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 Members times the applicable monthly capitation rate. 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 the 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 CHIP 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. 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.

5. Reserve Account

The Contractor shall establish and maintain an insured bank account or a secured investment which is in compliance with the Mississippi Insurance Department regulations referenced in Miss. Code Ann. § 83-41-325.

6. 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.

7. Third Party Resources

If a Member has CHIP third party resources (dental or vision) available for payment of medical 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 any payment.

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 Out-of-network 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 Out-of-network Provider is obligated to collect payment. If payment is made by the third party directly to a Subcontractor or Out-of-network Provider within sixty (60) calendar days following the date of service, the Contractor may pay the Subcontractor or Out-of-network 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 Out-of-network Provider and obtain a refund of any subsequent payments made by the third party. The Contractor may not withhold payment from a Subcontractor or Out-of-network 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 Out-of-network Provider and the Contractor must pursue recovery from the liable Third Party Resource.

8. Capitation Payments During Implementation Period

During the implementation period, January 1, 2019 to June 30, 2019, the Division will not make monthly capitation payments to any contracted entities under this contract. The Division will make State Fiscal Year (SFY) 2020 capitation payments to any contracted entities under this contract after July 1, 2019. Thus, the Division will not submit a capitation rate letter to CMS for approval for the implementation time period of January 1, 2019 to June 30, 2019.

B. **Indemnification and Insurance**

To the fullest extent allowed by law, the Contractor shall indemnify, defend, save, and hold harmless, protect, and exonerate the Division, the State of Mississippi, their commissioners, board members, officers, Agents, employees, representatives, assignees, Members and eligible dependents, and contractors from and against all claims, demands, liabilities, suits, Adverse Benefit Determinations, damages, losses, and costs of every kind and nature whatsoever including, without limitation, court costs, investigative fees and expenses, and attorney's fees, arising out of or caused by the Contractor and/or its partners, principals,

agents, employees, laborers, and/or subcontractors in the performance of or failure to perform this Contract, including:

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 the Contractor's negligence to any participating Provider or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract.
2. To indemnify and hold harmless the State, its officers, Agents, and employees, and the Members and their eligible dependents from liability deriving or resulting from the Contractor's Insolvency or inability or failure to pay or reimburse participating Providers or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract.
3. To indemnify and hold harmless the State, its officers, Agents, and employees, and the Members and their eligible dependents from any and all claims for services for which the Contractor receives monthly Capitation Payments, 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 Contract 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 the 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.

In the Division's sole discretion, the Contractor may be allowed to control the defense of any such claim, suit, etc. In the event the Contractor defends said claim, suit, etc., the Contractor shall use legal counsel acceptable to the Division. The Contractor shall be solely responsible for all costs and/or expenses associated with such defense, and the Division shall be entitled to participate in said defense. The Contractor shall not settle any claim, suit, etc. without the Division's concurrence, which the Division shall not unreasonably withhold.

C. No 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 through 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.

D. Federal, State, and Local Taxes

The Contractor understands and agrees that the State is exempt from the payment of 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.

E. Medical Loss Ratio

The Contractor shall provide quarterly and annual Medical Loss Ratio (MLR) reports as specified by the Division and in accordance with Exhibit D, Medical Loss Ratio (MLR) Calculation Methodology, of this Contract. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%) of the capitation payments received by the Contractor during the period, the Contractor shall refund the Division the difference by no later than the tenth (10th) business day of May following the end of the MLR Reporting Year. Any unpaid balances after the tenth (10th) business day of May shall be subject to interest of ten percent (10%) per annum.

See Exhibit D of this Contract for MLR calculation methodology and classification of costs.

F. Responsibility for Inpatient and Maternity Services

1. Inpatient Services

When an eligible Member is hospitalized, and the Member switches to another Contractor during the inpatient hospital stay, the Division requires the Contractor at the time of admission be responsible for the payment of all covered inpatient facility services provided. The payer at the date of admission remains responsible for the inpatient facility services until the date of discharge. This is not applicable for practitioners. Professional charges for services rendered during the inpatient stay must be submitted to the payer for date of service.

2. Maternity Services

The Contractor shall be responsible for payment of all maternity services related to a pregnancy for Members enrolled in CHIP and with the Contractor at the time of delivery. If the Member is determined to be eligible for Medicaid, the Division will transmit a termination of eligibility date to the Contractor, along with the code indicating the reason for termination, via the eligibility/enrollment update. Coverage will continue until such time as the Contractor receives a termination code from the Division.

G. Physician Incentive Plan

The Contractor may only operate a Physician Incentive Plan (PIP) if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an incentive to reduce or limit Medically Necessary services to a Member.

If the Contractor puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the Contractor must ensure that the physician/physician group has adequate stop-loss protection.

H. Health Insurance Providers Fee

Consistent with guidance issued by the IRS, and as otherwise permitted by law, the Division

will reimburse Contractor Annually the full cost of the Health Insurance Providers Fee that Contractor incurs, becomes obligated to pay, and does actually pay pursuant to section 9010 of the PPACA. This provision shall not apply for any time period during which a moratorium or suspension of the collection of the Health Insurance Providers Fee occurs. Contractor shall provide all documentation requested by the Division in a timely manner in order for the Division to verify that Contractor incurred, became obligated to pay, and did actually pay the full cost of the Health Insurance Providers Fee. For purposes of this section, the “full cost of the Health Insurance Providers Fee” shall be the sum of: (1) the Health Insurance Providers Fee that Contractor incurred, became obligated to pay, and actually did pay pursuant to section 9010 of the ACA, and (2) the tax liability that Contractor incurred, became obligated to pay, and actually paid, if any, related to the Division’s reimbursement to Contractor of the Health Insurance Providers Fee limited to Contractor’s Federal income tax, State income tax, and State premium tax liability attributable to such reimbursement. Notwithstanding the foregoing, the Division shall not compensate the Contractor for any additional Federal income tax and State income tax that the Contractor incurs because of the Division’s reimbursement to Contractor of any tax liability pursuant to the preceding sentence. In the event that the Contractor receives a refund from the Internal Revenue Service due to an overpayment of the Health Insurance Providers Fee, as provided to the Contractor from the IRS on an amended Letter 5067C, such refunded amount shall be paid by Contractor to the Division plus an amount equal to any reduction in the Contractor’s Federal income tax, State income tax, and/or State premium tax liability attributable to such refund.

SECTION 13 – THIRD PARTY LIABILITY (TPL)

The Contractor shall pursue payments from liable third parties in accordance with the State Plan and applicable federal and state laws and regulations. If the Contractor desires to Subcontract with any individual, firm, corporation, or any other entity, the Contractor shall abide by the requirements of Section 14 (Subcontractual Relationships and Delegation) in regard to any such Subcontract.

When handling a subrogation case, all initial letters sent to third parties (i.e., attorneys or insurance companies) should place the third party on notice that the Division may have a separate lien for services not covered by the Contractor and provide contact information for the Division's designated third party staff member. Under no circumstances may the Contractor or any Subcontractor imply that they are an Agent of the State or the 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, Non-Compliance 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 the Division of Medicaid; however, it is appropriate to state that the Contractor provides services for the Division of Medicaid.

The Contractor must educate insurers and attorneys who are representing the Contractor about Mississippi Medicaid and the CHIP Program, the differences between the two (2) programs and how representation for issues related to the Contractor's role in management of the CHIP Program do not imply representation for the full Medicaid program. Education must clarify that at no point may an insurer or attorney imply that they are representing

Medicaid, acting as an Agent of the State, or imply they are settling on behalf of the State or the Division of Medicaid.

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 the 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 the 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 subject to Division approval. The Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with the Division. Any Subcontract into which the Contractor enters with respect to performance under the Contract shall in no way relieve the Contractor of the legal responsibility to carry out the terms of this Contract. The Division will consider the Contractor to be the sole point of contact 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.

If the Contractor delegates any activities or obligations under this Contract to a Subcontractor, the following conditions must be met:

1. The delegated activities or obligations, and related reporting responsibilities, are specified in the Contract or written agreement with the Subcontractor;
2. The Subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's obligations under this Contract; and
3. The Contract or written agreement between the Contractor and Subcontractor must

either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Division or the Contractor determine that the Subcontractor has not performed satisfactorily.

4. The Subcontractor agrees that the Division, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Contract.
5. The Subcontractor will make available, for the purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of 42 C.F.R. §438.230, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid Members.
6. The right to audit under paragraph (c)(3)(i) of 42 C.F.R. §438.230 will exist through ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

If the Division, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Division, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

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 the Division required terms and conditions. At contract execution, the Division will provide a checklist of specific requirements that the Contractor must include in every Subcontract supporting CHIP. 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, business, university, governmental entity, affiliate, subsidiary, nonprofit organization, 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/Substance Use Disorder 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 and supporting documentation to the Division for advance written approval not less than thirty (30) calendar days in advance of its desire to Subcontract. If such Subcontract is approved, the Contractor shall notify the Division not less than thirty (30) calendar days in advance of its desire to amend or terminate such Subcontract. The Contractor shall include a copy of the proposed Subcontract amendment with notification of and information about the proposed

amendment. The proposed amendment must receive written approval from the Division prior to its effective date.

When requested by the Division, any subcontract between a Subcontractor and any individual, firm, corporation, business, university, governmental entity, affiliate, subsidiary, nonprofit organization, or any other entity to perform part or all of the Contractor's responsibilities under this Contract that have been subcontracted to the Subcontractor, shall be submitted to the Division for review not less than thirty (30) calendar days in advance of the Subcontractor's desire to subcontract (or amend or terminate such 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 and/or remedies 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 CHIP 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 CHIP Provider.

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 XXI 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.

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 XXI Services Program.

The Contractor shall give the Division immediate written notice by certified mail, facsimile, or any other carrier that requires signature upon receipt of any Adverse Benefit Determination 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 – NON-COMPLIANCE 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 to the satisfaction of the Division, the Division shall have the right to exercise any of the administrative sanction options described in this section, in addition to any other rights and remedies that may be available to the Division:

1. 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;
2. Suspension or recoupment of the capitation rate paid for:
 - a. 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 (\$25,000.00). The Contractor shall be given at least fifteen (15) calendar days from the date of the written notice prior to the withholding of any Capitation Payment;
 - b. 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 and to the satisfaction of the Division;
 - c. Members enrolled after the effective date of any sanctions imposed herein, and until CMS or the State is satisfied that the reason for imposition of the

sanction no longer exists and is not likely to recur.

1. Notwithstanding the provisions contained in this Contract, the Division may withhold portions of Capitation Payments from the Contractor as provided herein;
2. Civil money penalties of up to one hundred thousand dollars (\$100,000.00) for acts of discrimination against individuals on the basis of their health status or need for health care services, or Providers, or misrepresentation or falsification of information furnished to CMS or the Division;
3. Civil money penalties of up to twenty-five thousand dollars (\$25,000.00) for misrepresentation or falsification of information furnished to individuals or Providers, or for failure to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210, or the Division determines that the Contractor has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Division or that contain false or materially misleading information;
4. Civil money penalties of up to twenty-five thousand dollars (\$25,000.00), or double the amount of excess charges, whichever is greater, for premiums or charges in excess of the amounts permitted under the Medicaid program;
5. Temporary management upon a finding by the Division that the Contractor has repeatedly failed to meet substantive requirements of this Contract, there is continued egregious behavior by the Contractor, there is substantial risk to the health of Members, or it is necessary to ensure the health of the Members, in accordance with § 1932 of the Social Security Act;
6. Termination of this Contract;
7. Reduce or eliminate Marketing and/or community event participation;
8. Refuse to allow participation in Contractor pay for performance programs;
9. Refuse to renew the Contract;
10. In the case of inappropriate Marketing activities, referral may also be made to the Mississippi Insurance Department for review and appropriate enforcement action;
11. 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;

12. 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;
13. Refuse to consider for future contracting a Contractor that fails to submit Member Encounter Data on a timely and accurate basis;
14. Refer any matter to the applicable Federal agencies for civil money penalties;
15. Refer any matter to the state and/or federal agencies responsible for investigating or addressing civil rights matters, where applicable;
16. Exclude the Contractor from participation in the Medicaid program;
17. Refer any matter to the state or federal agencies responsible for investigating or addressing Consumer Affairs matters, where applicable; and,
18. Impose any other sanctions as provided by 42 C.F.R. § 438.700 et. seq.

The Division shall provide the Contractor written notice fifteen (15) calendar days before sanctions as specified above are imposed, which will include the basis and nature of the sanction. The type of action taken shall be in relation to the nature and severity of the deficiency. The basis for imposition of sanctions under this section includes, but is not limited to:

- a. The Division determines that Contractor acts or fails to act as follows:
 - i. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under this Contract, to a Member covered under the Contract.
 - ii. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
 - iii. Acts to discriminate among Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a Member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by Members whose medical condition or history indicates probable need for substantial future medical services.
 - iv. Misrepresents or falsifies information that it furnishes to CMS or to

the Division.

- v. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care Provider.
 - vi. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210.
- b. The Division determines that the Contractor has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Division or that contain false or materially misleading information.
 - c. The Division determines that the Contractor has violated any of the requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

The Division retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in this section shall prevent the Division from exercising that authority.

B. Disputes of Sanctions or Damages

In order to Appeal the Division imposition of any sanctions or damages, the Contractor shall request review in accordance with the Disputes provisions provided in Section 16.J. 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

The Division, the Mississippi Department of Audit, HHS, CMS, OIG, Comptroller General, 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 the Contractor of the Division, CMS, the Division's Agent, and the Division's Program Integrity Bureau 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, in accordance with 42 C.F.R.

§ 457.950. 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 the 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, UM, and evaluation purposes, emphasis will be placed on case record validation during periodic monitoring visits to project sites. The Division shall prepare a report of its findings and recommendations and require the Contractor to develop a CAP to address any deficiencies.

The right to audit exists for ten (10) years from the final date of the contracted period or from the date of completion of any audit, whichever is later.

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 CAP be filed within fifteen (15) calendar days following the date of the notice. A CAP shall delineate the time and manner in which each deficiency is to be corrected. The CAP 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.

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 Damages

Failed Deliverable	Damages
Administrative Service	For each day Contractor fails to timely perform an Administrative Service that in the Division's determination results in harm to a Member, places a Member at risk of harm, or affects the Division's ability to administer the program, the Division may assess up to \$5,000.00 per calendar day for each incident of noncompliance.
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 shall pay liquidated damages of up to ten thousand dollars (\$10,000.00) per monthly period.
Claims Payment	If the Contractor fails to meet the targets outlined in Section 17. A., Claims Payment, of this Contract, the Division shall deem this to be an instance of unsatisfactory claims performance and the Contractor shall pay liquidated damages 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 CHIP 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.

Failed Deliverable	Damages
Covered Service	<p>For each day the Contractor fails to timely provide a Covered Service that in the Division's determination results in harm to a Member, places a Member at risk of harm, or affects the Division's ability to administer the program, the Division may assess up to \$7,500.00 per calendar day for each member affected by the noncompliance.</p>
Member Encounter Data	<p>The Contractor shall 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 Member Encounter Data to the Division that meets Federal and Division requirements and allows the Division to monitor the program. The Division will establish minimum standards for financial and administrative accuracy and for timeliness of processing. These standards will be no less than the standards currently in place for the Medicaid fee-for-service program.</p> <p>If the Contractor does not meet these standards, the Contractor may be assessed liquidated damages each month Member Encounter Data is not submitted or not submitted in compliance with the Division's requirements for timeliness, completeness, and accuracy. If the Contractor fails to submit data derived from processed encounter claims in the required form or format by the terms of this Contract for one (1) calendar month, the Division shall withhold an amount equal to five percent (5%) of the Contractor's capitation payment for the month following non-submission and shall retain the amount withheld until the data is received, reviewed, and accepted by the Division. Additionally, the Division may assess liquidated damages up to the following amounts:</p> <p>Ten thousand dollars (\$10,000.00) per calendar day for each day Member Encounter Data is received after the due date,</p> <p>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</p> <p>Ten thousand dollars (\$10,000.00) per calendar day for each day the Contractor fails to correct and resubmit Member Encounter Data that was originally returned to the Contractor for correction because the error rate for the submitted data was in excess of the five percent (5%), until acceptance.</p>
Well-Care Child Assessments and Immunizations	<p>Failure to achieve the targets specified in Table 8 of this Contract will require a refund of one hundred dollars (\$100.00) per Member for all Well-Care Child Eligible Members who did not receive the required screening or immunization. The Division will periodically re-evaluate this level and notify the Contractor in writing of changes.</p>

Failed Deliverable	Damages				
General Deliverables and Reports	For each day that a Deliverable or required report is late, incorrect or deficient, the Contractor may be liable to the Division for liquidated damages in an amount per calendar day per Deliverable as specified in the table below for reports and Deliverables not otherwise specified in this table. Liquidated damages have been designed to escalate by duration and by occurrence over the term of this Contract.				
	Occurrence	Daily Amount for Days 1-14	Daily Amount for Days 15-30	Daily Amount for Days 31-60	Daily Amount for Days 61 and Beyond
	1-3	\$750	\$1,200	\$2,000	\$3,000
	4-6	\$1,000	\$1,500	\$3,000	\$5,000
	7-9	\$1,500	\$2,000	\$4,000	\$6,000
	10-12	\$2,000	\$3,000	\$5,000	\$8,000
13 and Beyond	\$4,000	\$7,000	\$9,500	\$12,000	
Marketing	If the Division determines that the Contractor has violated the requirements of the Contractor’s obligations with respect to Marketing and Marketing materials, the Contractor shall pay up to twenty-five thousand dollars (\$25,000.00) for each violation.				
Medicaid Investigated Grievances	If the Contractor is subject to more than three (3) valid Medicaid Investigated Grievances in any one (1) month, The Division may assess liquidated damages of up to ten thousand dollars (\$10,000.00) for each such valid Medicaid Investigated Grievance above three (3) per month.				
Network Access Report and Provider Network Reports	<p>If the Division determines that the Contractor has not met the established Provider Network access standards, the Division shall assess liquidated damages on the Contractor and require submission of a Correction Action Plan to the Division within fifteen (15) business days following assessment of liquidated damages. Determination of failure to meet network access standards shall be made following a review of the Contractor’s Network Geographic Access Assessment (GeoAccess) Report.</p> <p>Contractor shall pay 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 CHIP 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.</p>				
Physician Incentive Plan	If Contractor fails to comply with the Section 7.K., Physician Incentive Plan, the Division may assess liquidated damages of up to twenty-five thousand dollars (\$25,000.00) for each failure to comply.				

Failed Deliverable	Damages
Provider Credentialing	If the Division determines that the Contractor has not completed credentialing of Providers within ninety (90) calendar days, or if the approved Credentialing application is not loaded in the Contractor's Claims Processing system within thirty (30) days after approval, the Division may impose liquidated damages of up to five thousand dollars (\$5,000.00) per violation.
Premium	If Contractor imposes premiums or charges on Members that are in excess of those permitted, the Division may assess liquidated damages of up to twenty-five thousand dollars (\$25,000.00) or double the amount of the excess charges, whichever is greater. The Division will also deduct the amount of the overcharge from assessed liquidated damages and return it to the affected Members.
Prior Authorizations	<p>If the Contractor fails to meet the Prior Authorization performance standards for the completion timelines for review determinations, the Division may assess liquidated damages in the amount of one hundred dollars (\$100.00) per workday for each failure to meet the performance standard.</p> <p>If the Contractor fails to meet the Prior Authorization performance standards for the completion timelines for review determination notification, the Division may assess liquidated damages in the amount of one hundred dollars (\$100.00) per workday for each failure to meet the performance standard.</p>
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 liquidated damages 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 assessment of liquidated damages in the amount of one (1) month's Capitation Payment rates for each day that the Subcontractor was in effect without the Division's approval.
Business Associate Agreement/Protected Health Information	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of MississippiCAN member PHI or MississippiCAN confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party, the Division may impose liquidated damages of five hundred dollars (\$500) per enrollee per occurrence.

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) one hundred percent (100%) 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. If, however, the report(s) submitted for a subsequent reporting period has the same errors or deficiencies identified by a previous written notice from DOM, the report will be considered late and the liquidated damages will be assessed based on the date the report was due.

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.

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.

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 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 MMIS/MES 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 and zero cents (\$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 Section 15.E.2., Termination of the Contract, relating to liquidated damages does not apply if the Contract is terminated without cause in accordance with Section 15.H, Option to Terminate.

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. Action by the Mississippi Insurance Department

Upon receipt of official notice that the Mississippi Insurance Department has taken action which resulted in the Contractor being placed under administrative supervision, the Division will suspend further Enrollment of CHIP Members until notice is received from the Mississippi Insurance Department that administration supervision is no longer needed.

Upon receipt of official notice that the Mississippi Insurance Department has taken action, which resulted in the Contractor being placed in rehabilitation, the Division will immediately disenroll all Members who are CHIP Members and suspend further Enrollment of CHIP Members until notice is received from the Mississippi Insurance Department that the Contractor has been rehabilitated. If the Division disenrolls CHIP Members before the end of the month, the Rehabilitator will be notified of the prorated amount of payment due to the Division for the days of the month not covered by the Contractor for each CHIP 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.

H. Option to Terminate

This Contract may be terminated without cause by either party upon ninety (90) calendar day 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.

I. 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
- b. For non-availability of funds. (See also Section 4.3.2, Termination of Contract, of the Mississippi CHIP RFQ for additional requirements.)

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 funds or of the State of Mississippi to appropriate funds or the discontinuance or material alteration of the program under which funds were provided or if funds are not otherwise available to the Division, the Division shall have the right upon ten (10) working days written notice to Contractor, to terminate this Contract without damage, penalty, cost or expenses to the Division of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

TERMINATION FOR CONVENIENCE (1) Termination. The Agency Head or designee may, when the interests of the State so require, terminate this Contract in whole or in part, for the convenience of the State. The Agency Head or designee shall give written notice of the termination to Contractor specifying the part of the Contract terminated and when termination becomes effective. (2) Contractor's Obligations. Contractor shall incur no further obligations in connection with the terminated work and on the date set in the notice of termination Contractor will stop work to the extent specified. Contractor shall also terminate outstanding orders and subcontracts as they relate to the terminated work. Contractor shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated work. The Agency Head or designee may direct Contractor to assign Contractor's right, title, and interest under terminated orders or subcontracts to the State. Contractor must still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so.

TERMINATION FOR DEFAULT (1) Default. If Contractor refuses or fails to perform any of the provisions of this Contract with such diligence as will ensure its completion within the time specified in this Contract or any extension thereof, or otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of this Contract, the Agency Head or designee may notify Contractor in writing of the delay or nonperformance and if not cured in ten (10) days or any longer time specified in writing by the Agency Head or designee, such officer may terminate Contractor's right to proceed with the Contract or such part of the Contract as to which there has been delay or a failure to properly perform. In the event of termination in whole or in part, the Agency Head or designee may procure similar supplies or services in a manner and upon terms deemed appropriate by the Agency Head or designee. Contractor shall continue performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services. (2) Contractor's Duties. Notwithstanding termination of the Contract and subject to any directions from the Chief Procurement Officer, Contractor shall take timely, reasonable, and necessary action to protect and preserve property in the possession of Contractor in which the State has an interest. (3) Compensation. Payment for completed services delivered and accepted by the State shall be at the Contract price. The State may withhold from amounts due Contractor such sums as the Agency Head or designee deems to be necessary to protect the State against loss because of outstanding liens or claims of former lien holders and to reimburse the State for the excess costs incurred in procuring similar goods and services. (4) Excuse for Nonperformance or Delayed Performance. Except with respect to defaults of Subcontractors, Contractor shall not be in default by reason of any failure in performance of this Contract in accordance with its terms (including any failure by Contractor to make progress in the prosecution of the work hereunder which endangers such performance) if Contractor has notified the Agency Head or designee within fifteen (15) calendar days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of the public enemy; acts of the State and any other governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe

weather. If the failure to perform is caused by the failure of a Subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, Contractor shall not be deemed to be in default, unless the services to be furnished by the Subcontractor were reasonably obtainable from other sources in sufficient time to permit Contractor to meet the Contract requirements. Upon request of Contractor, the Agency Head or designee shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, Contractor's progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the State under the clause entitled (in fixed-price contracts, "Termination for Convenience," in cost-reimbursement contracts, "Termination"). (As used in this Paragraph of this clause, the term "Subcontractor" means Subcontractor at any tier). (5) Erroneous Termination for Default. If, after notice of termination of Contractor's right to proceed under the provisions of this clause, it is determined for any reason that the Contract was not in default under the provisions of this clause, or that the delay was excusable under the provisions of Paragraph (4) (Excuse for Nonperformance or Delayed Performance) of this clause, the rights and obligations of the parties shall, if the Contract contains a clause providing for termination for convenience of the State, be the same as if the notice of termination had been issued pursuant to such clause. (6) Additional Rights and Remedies. The rights and remedies provided in this clause are in addition to any other rights and remedies provided by law or under this Contract.

TERMINATION UPON BANKRUPTCY This Contract may be terminated in whole or in part by the Division upon written notice to Contractor, if Contractor should become the subject of bankruptcy or receivership proceedings, whether voluntary or involuntary, or upon the execution by Contractor of an assignment for the benefit of its creditors. In the event of such termination, Contractor shall be entitled to recover just and equitable compensation for satisfactory work performed under this Contract, but in no case shall said compensation exceed the total Contract price.

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 sending the possible termination notice 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 and to the satisfaction of 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 and does not resolve the failure to the satisfaction of the Division, 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 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 and 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 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 Bankruptcy Reform Act of 1978 (Pub.L. 95-598) or any other Federal or state statute 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.

J. Procedure on Termination

1. Notice of Termination

Upon termination of the Contract for any reason except as described in Section 15.G, Action by the Mississippi Insurance Department, 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 Contractor, as appropriate.

If the Contract is terminated because the Contractor is not in compliance with terms of this Contract and if directed by CMS, the Division cannot renew or otherwise extend this Contract for the Contractor unless CMS determines that compelling reasons exist for doing so.

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:

STOP WORK ORDER (1) Order to Stop Work: The Chief Procurement Officer, may, by written order to Contractor at any time, and without notice to any surety, require Contractor to stop all or any part of the work called for by this Contract. This order shall be for a specified period not exceeding ninety (90) calendar days after the order is delivered to Contractor, unless the parties agree to any further period. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, Contractor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allocable to the work covered by the order during the period of work stoppage. Before the stop work order expires, or within any further period to which the parties shall have agreed, the Chief Procurement Officer 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, Contractor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or Contractor price, or both, and the Contract shall be modified in writing accordingly, if: (a) the stop work order results in an increase in the time required for, or in Contractor's cost properly allocable to, the performance of any part of this Contract; and, (b) Contractor asserts a claim for such an adjustment within 30 days after the end of the period of work stoppage; provided that, if the Chief Procurement Officer decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract. (3) Termination of Stopped Work: If a stop work order is not canceled and the work covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop work order shall be allowed by adjustment or otherwise. (4) Adjustments of Price: Any adjustment in Contract price made pursuant to this clause shall be determined in accordance with the Price Adjustment clause of this Contract.
- c. Stop work under the Contract on the date and to the extent specified in the Notice of Termination (See also Section 4.3.1, Stop Work Order, of the Mississippi CHIP RFQ for additional requirements.);
- 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 Members 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. The Division Responsibilities

Except for termination for the 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 16.J, Disputes, of this Contract from any such determination made by the Division.

K. 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.

L. 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 because 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.

M. 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 (12:00 AM) 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 Members and Medical Records to other appropriate Providers as directed by the Division;
5. Supply to the Division such information as it may request respecting any unpaid claims submitted by Out-of-network Providers and arrange for the payment of such claims within the time periods provided herein;
6. Take such action as may be necessary, or as the Division may direct, for the protection of property related to this Contract, which is in the possession of the Contractor and in which the Division has or may acquire an interest; and
7. Provide for the maintenance of all records for audit and inspection by the Division or its Agents, CMS 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. Privacy/Security Compliance

The Contractor shall abide by all applicable Federal and/or State rules and/or regulations including, the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (as amended by the Genetic Information Nondiscrimination Act (GINA) of 2008 and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act (ARRA) of 2009) and its implementing regulations at 45 C.F.R. Parts 160, 162, and 164, including EDI, code sets, identifiers, security, and privacy provisions as may be applicable to the services under this Contract, and shall sign a Business Associate Agreement and any Data Use Agreement(s) and/or Nondisclosure Agreement(s) that the Division determines to be necessary.

To the extent that the Contractor uses one (1) or more Subcontractors or agents to provide services under this Contract, and such Subcontractors or agents receive or have access to 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 or anytime thereafter.

B. Conflict of Interest

In accordance with 42 C.F.R. §438.58 and 1902(a)(4)(C) and 1932(d)(3) of the Social Security Act, the Contractor shall comply with conflict of interest safeguards with respect to officers, contracting officers, employees, and independent contractors of the Division having responsibilities relating to this Contract. The Division shall comply with conflict of interest safeguards on the part of Division officers, employees, and agents who have responsibilities relating to this Contract or the enrollment processes specified in 42 C.F.R. § 438.54(b). Such safeguards shall be at least as effective as described in section 27 of the Federal Procurement Policy Act (41 U.S.C. § 423).

The Contractor shall have no interest and shall not acquire any interest, direct or indirect, 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, or 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 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 certifies that no Member of Congress, nor any elected or appointed official, employee or Agent of the State of Mississippi, HHS, CMS, or any other Federal agency, has or will benefit financially or materially from this Contract. This Contract will be terminated by the Division if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, its agents, employees, Subcontractors, or suppliers.

See also Section 4.8, Representation Regarding Contingent Fees, and Section 4.16.7, Bribes, Gratuities, and Kickbacks Prohibited, of the Mississippi CHIP RFQ for additional requirements.

REPRESENTATION REGARDING CONTINGENT FEES Contractor represents that it has not retained a person to solicit or secure a state contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except as disclosed in Contractor's bid or qualification.

REPRESENTATION REGARDING GRATUITIES The bidder, offeror, or Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Public

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 except within the confines of its role as a Contractor for the Division. 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 law, such as the Mississippi Ethics in Government Act. Miss. Code Ann. §§ 25-4-101 through 25-4-119.

3. Personnel Practices

All employees of the Contractor involved in the CHIP 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 the 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, as provided for under this Contract.

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 CHIP, except for Emergency Services.

The Contractor must comply with 42 C.F.R. § 455.436 and ensure that all the Contractor's 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 Contractor must comply with 42 C.F.R. § 455.436 requiring performance of the following:

1. Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases;
2. Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe;
3. Consult appropriate databases to confirm identity upon enrollment and reenrollment; and

4. Check the LEIE and EPLS no less frequently than monthly.

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 CHIP Members.

F. Compliance with Federal Laws

The Contractor and its Subcontractors shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. § 7606), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and applicable United States Environmental Protection Agency (EPA) regulations, 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 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 Conservation Contract issued in compliance with the Energy Policy and Conservation Act (Pub. L.94-163).

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 PPACA.

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 part, term, or provision of this Contract (including items incorporated by reference) is declared by the courts or other judicial body 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, shall 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 Executive Administrator of the Division. Such decision shall be in writing and mailed or otherwise furnished to the Contractor. The decision of the Executive Administrator 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. 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 Division's Executive Administrator 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 Contract 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, HHS, 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 or its agents, employees, representatives, assignees, and Subcontractors 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, HHS, CMS, and the State of Mississippi and to their officers, Agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver, and dispose of all such information now covered by copyright of the proposed Contractor.

Excluded from the foregoing provisions in this subsection, however, are any pre-existing, proprietary tools owned, developed, or otherwise obtained by the Contractor independent of this Contract. The 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 Contract, 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.

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 Section 16.J, Disputes, 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 CHIP 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. **Employment Practices**

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, ancestry, limited English proficiency, physical handicap, disability, or any other consideration made unlawful by Federal, State, or local laws, 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, national origin, sex, sexual orientation, gender, gender identity or disability, 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 (Pub.L. 88-352), and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Rehabilitation Act of 1973 (29 U.S.C. § 701 *et seq.*), as amended, and related State laws and regulations, if any.

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.

See also Section 4.16, Compliance with Laws, and Section 4.16.10, E-Verification, of the Mississippi CHIP RFQ for additional requirements.

COMPLIANCE WITH LAWS Contractor understands that the State is an equal opportunity employer and therefore, maintains a policy which prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, genetic information, or any other consideration made unlawful by federal, state, or local laws. All such discrimination is unlawful and Contractor agrees during the term of the agreement that Contractor will strictly adhere to this policy in its employment practices and provision of services. Contractor shall comply with, and all activities under this agreement shall be subject to, all applicable federal, State of Mississippi, and local laws and regulations, as now existing and as may be amended or modified.

E-VERIFICATION If applicable, Contractor represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act of 2008, and will register and participate in the status verification system for all newly hired employees. Mississippi Code Annotated §§ 71-11-1 et seq. The term “employee” as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, “status verification system” means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. Contractor agrees to maintain records of such compliance. Upon request of the State and after approval of the Social Security Administration or Department of Homeland Security when required, Contractor agrees to provide a copy of each such verification. Contractor further represents and warrants that any person assigned to perform services hereafter meets the employment eligibility requirements of all immigration laws. The breach of this agreement may subject Contractor to the following:

- (1) termination of this Contract for services and ineligibility for any state or public contract in Mississippi for up to three (3) years with notice of such cancellation/termination being made public;
- (2) the loss of any license, permit, certification or other document granted to Contractor by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year; or,
- (3) both. In the event of such cancellation/termination, Contractor would also be liable for any additional costs incurred by the State due to Contract cancellation or loss of license or permit to do business in the State.

O. 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 Section 1352 of Title 31, United States 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.

P. Transparency

See also Section 4.15.2, Release of Public Information, and Section 4.15.4, Transparency, of the Mississippi CHIP RFQ for additional requirements.

TRADE SECRETS, COMMERCIAL AND FINANCIAL INFORMATION It is expressly understood that Mississippi law requires that the provisions of this Contract which contain the commodities purchased or the personal or professional services provided, the price to be paid, and the term of the contract shall not be deemed to be a trade secret or confidential commercial or financial information and shall be available for examination, copying, or reproduction.

TRANSPARENCY This Contract, including any accompanying exhibits, attachments, and appendices, is subject to the "Mississippi Public Records Act of 1983," and its exceptions. See Mississippi Code Annotated §§ 25-61-1 et seq. and Mississippi Code Annotated § 79-23-1. In addition, this Contract is subject to the provisions of the Mississippi Accountability and Transparency Act of 2008. Mississippi Code Annotated §§ 27-104-151 et seq. Unless exempted from disclosure due to a court-issued protective order, a copy of this executed Contract is required to be posted to the Department of Finance and Administration's independent agency contract website for public access at <http://www.transparency.mississippi.gov>. Information identified by Contractor as trade secrets, or other proprietary information, including confidential vendor information or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes, will be redacted.

Q. State Approval

Approval from the Public Procurement Review Board must be received before Contract execution. Every effort will be made by the Division to facilitate rapid approval and a start date consistent with the proposed schedule.

APPROVAL CLAUSE It is understood that if this Contract requires approval by the Public Procurement Review Board and/or the Mississippi Department of Finance and Administration Office of Personal Service Contract Review and this Contract is not approved by the PPRB and/or OPSCR, it is void and no payment shall be made hereunder.

IN WITNESS WHEREOF, the parties have executed this Contract to be effective as of the [Insert Effective Date].

**FOR the
Division:**

**DIVISION OF MEDICAID
IN THE OFFICE OF THE
GOVERNOR STATE OF
MISSISSIPPI**

**BY: _____
Mr. Drew Snyder
EXECUTIVE DIRECTOR**

**FOR
CONTRACTOR:**

[Insert Vendor Name]

**BY: _____
[Insert Name]
PRESIDENT & CHIEF
EXECUTIVE OFFICER**

STATE OF MISSISSIPPI
COUNTY OF _____

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

GIVEN under my hand and official seal of office on this the _____ day of _____, A. D., 2015.

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, **[Insert Name]**, in her official capacity as the duly appointed **President and Chief Executive Officer of [Insert Vendor Name]**, who acknowledged to me, being first duly authorized by said entity that she signed and delivered the above and foregoing written Contractual Agreement for and on behalf of said entity, 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., 2018.

NOTARY PUBLIC

**MY COMMISSION
EXPIRES:**

EXHIBIT A: CAPITATION RATE DEVELOPMENT REPORT

(Attached under a separate cover)

EXHIBIT B: COVERED SERVICES

This Exhibit is provided for reference only within this Contract. The State Health Plan shall supersede this Exhibit. The Contractor shall comply with all requirements of the State Health Plan and 42 C.F.R. § 457 (as applicable).

Table A. Services

Covered Service	Description
Inpatient hospital services. (Section 2110(a)(1) of the Social Security Act)	<p>Must be pre-certified as medically necessary and includes the following:</p> <ol style="list-style-type: none">1. Hospital room and board (including dietary and general nursing services);2. Use of operating or treatment rooms;3. Anesthetics and their administration;4. Intravenous injections and solutions;5. Physical therapy;6. Radiation therapy;7. Oxygen and its administration;8. Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms;9. Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs;10. Dressings and supplies, sterile trays, casts, and orthopedic splints;11. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies;12. Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations;13. Intensive, coronary, and burn care unit services;14. Occupational therapy; and15. Speech therapy.
Outpatient hospital services (Section 2110(a)(2) of the Social Security Act)	See Physician Services and Surgical Services.

Physician services	<p>Includes the following:</p> <ol style="list-style-type: none"> 1. In-hospital medical care; 2. Medical care in the physician's office, Member's home, or elsewhere; 3. Surgery; 4. Dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled Child is covered under the program. Injury to teeth as a result of chewing or biting is not considered an accidental injury. Covered medical expense must be incurred as a direct result of an accidental injury to natural teeth and medical treatment must begin within ten (10) days of the accidental injury;
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Covered Service	Description
	<ol style="list-style-type: none"> 5. Administration of anesthesia; 6. Diagnostic services, such as clinical laboratory examinations, x-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests; 7. Radiation therapy; 8. Consultations; 9. Psychiatric and psychological service for nervous and mental conditions; 10. Physicians assisting in surgery, where appropriate; 11. Emergency care or surgical services rendered in a practitioner's office including but not limited to surgical and medical supplies, dressings, casts, anesthetic, tetanus, serum and x-rays; 12. Well-Child assessments, including vision screening, laboratory tests and hearing screening, according to recommendations of the U.S. Preventive Service Task Force; and 13. Routine immunizations (according to ACIP guidelines) -Vaccine is purchased and distributed through the State Department of Health. The health plan will reimburse Providers for the administration of the vaccine.
<p>Surgical services. (Section 2110(a)(4) of the Social Security Act)</p>	<p>Certain surgeries must be pre-certified as medically necessary.</p> <p>Benefits are provided for the following covered medical expenses furnished to the Member by an ambulatory surgical facility:</p> <ol style="list-style-type: none"> 1. Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure; 2. Pre-operative preparation; 3. Use of facility (operating rooms, recovery rooms, and all surgical equipment); 4. Anesthesia, drugs, and surgical supplies.
<p>Clinic services (including health center services) and other ambulatory health care services. (Section</p>	<p>Covered as medical services under Physician Services.</p>

<p>Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person. (Section 2110(a)(6) of the Social Security Act)</p>	<p>The following drugs and medical supplies are covered:</p> <ol style="list-style-type: none"> 1. Legend drugs (Federal law requires these drugs be dispensed by prescription only); 2. Compounded medication of which at least one ingredient is a legend drug; 3. Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes- Tape); 4. Disposable insulin needles/syringes; 5. Growth hormones; 6. Insulin; 7. Lancets; 8. Legend contraceptives; 9. Retin-A ; 10. Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets); and 11. Vitamin and mineral supplements, for Members up to age 21 years. when prescribed as replacement therapy.
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Covered Service	Description
2110(a)(6) of the Social Security Act)	<p>The following are excluded:</p> <ol style="list-style-type: none"> 1. Anabolic steroids (e.g., Winstrol, Durabolin); 2. Anorectics (any drug used for the purpose of weight loss) with the exception of Dexadrine and Adderall for Attention Deficit Disorder; 3. Anti-wrinkle agents (e.g., Renova); 4. Charges for the administration or injection of any drug; 5. Dietary supplements not listed on the PDL 6. Infertility medications (e.g., Clomid, Metrodin, Pergonal, Profasi); 7. 8. Minoxidil (Rogaine) for the treatment of alopecia; 9. Non-legend drugs other than those listed as covered in the MS Covered OTC Drugs list; 10. Pigmenting/depigmenting agents; 11. Drugs used for cosmetic purposes; 12. 13. Therapeutic devices or appliances, including needles, syringes, support garments, and other non-medicinal substances, regardless of intended use, except those listed as covered, such as insulin needles and syringes; 14. 15. Investigative drugs and drugs used other than for the FDA approved diagnosis; 16. Drugs that do not require a written prescription; 17. ; and 18. Refills in excess of the number specified by the practitioner or any refills dispensed more than one (1) year after the date of practitioner's original prescription.
Laboratory and radiological services. (Section 2110(a)(8) of the Social Security Act)	Certain diagnostic tests must be pre-certified.
Prenatal care and Pre-pregnancy family planning services and supplies. (Section 2110(a)(9) of the Social Security Act)	Infertility services are excluded.

Covered Service	Description
<p>Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services. (Section 2110(a) (10) of the Social Security Act)</p>	<ol style="list-style-type: none"> 1. Benefits for covered medical expenses are paid for medically necessary inpatient psychiatric treatment of a Member. 2. Benefits for covered medical expenses are provided for partial hospitalization. 3. Certification of medical necessity by the Contractor's UM program is required for admissions to a hospital. Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.
<p>Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a State-operated mental hospital and including community-based services. (Section 2110(a) (11) of the Social Security Act)</p>	<p>Benefits for covered medical expenses for treatment of nervous and mental conditions on an outpatient basis.</p> <p>Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.</p>

<p>Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). (Section 2110(a) (12) of the Social Security Act)</p>	<p>Rental of durable medical equipment is covered for temporary therapeutic use; provided, however, at the Contractor's discretion, the purchase price of such equipment may be allowed. To be durable medical equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose; (3) generally not useful to a person in the absence of illness, injury or disease; and (4) appropriate for use in the Member's home.</p> <p>Prosthetic or orthotic devices necessary for the alleviation or correction of conditions arising from accidental injury, illness, or congenital abnormalities are covered services. Benefits are available for the initial placement, fitting, and purchase of prosthetic or orthotic devices that require a prescription by a physician and for the repair or replacement when medically necessary. Shoes are not covered except for the following: (1) a surgical boot which is part of an upright brace; (2) one pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes; and (3) a custom fabricated shoe in the case of a significant foot deformity.</p> <p>Eyeglasses (limited to one (1) per year) and hearing aids (limited to one (1) every three (3) years) are covered services.</p>
<p>Disposable medical supplies. (Section 2110(a) (13) of the Social Security Act)</p>	<p>Supplies provided under the plan which are medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a Member to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease, and are appropriate for use in the Member's home.</p>

Covered Service	Description
<p>Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home) (See instructions). (Section 2110(a)(14) of the Social Security Act)</p>	<p>Services and supplies required for the administration of home infusion therapy regimen must be (1) medically necessary for the treatment of the disease; (2) ordered by a practitioner; (3) as determined by the Contractor's UM program capable of safe administration in the home; (4) provided by a licensed home infusion therapy Provider coordinated and pre-certified by the Contractor's UM program ; (5) ordinarily in lieu of inpatient hospital therapy; and (6) more cost effective than inpatient therapy.</p> <p>Benefits for home health nursing services must be approved by the Contractor's UM program in lieu of hospitalization. Benefits for nursing services are limited to ten thousand dollars and zero cents (\$10,000.00) annually.</p>

<p>Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting. (Section 2110(a)(15) of the Social Security Act)</p>	<p>Benefits include nursing services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered and supervised by a practitioner and when the services rendered require the technical skills of an RN or LPN.</p> <p>Benefits are provided for covered medical expense when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered.</p> <p>Benefits for private duty nursing services are provided for an illness or injury that the Contractor's UM program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. Benefits are also provided for nursing services in the home for illness or injury that the Contractor's UM program determines to require the skills of an RN or LPN. Benefits for nursing services provided in a Member's home must be approved by the Contractor's UM program in lieu of hospitalization. Benefits for nursing services are limited to ten thousand dollars and zero cents (\$10,000.00) annually. (This limit does not apply to nurse practitioner services.)</p> <p>No nursing benefits are provided for:</p> <ol style="list-style-type: none"> 1. Services of a nurse who ordinarily lives in the Child's home or is a member of the Child's family; 2. Services of an aide, orderly or sitter; or 3. Nursing services provided in a personal care facility. <p>Benefits are provided for confinement in a skilled nursing facility for up to sixty (60) days per Benefit Period, subject to UM requirements.</p>
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Covered Service	Description
Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2110(a)(16) of the	Benefits are allowed for elective abortion only when documented to be medically necessary in order to preserve the life or physical health of the mother. (Refer to Abortion Form)

<p>Dental services. (Section 2110(a)(17) of the Social Security Act) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)</p>	<p>Covered dental services are limited to two thousand dollars and zero cents (\$2,000.00) each calendar year</p> <ol style="list-style-type: none"> 1. Benefits will be provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD). <ol style="list-style-type: none"> a. Bitewing X-rays - as needed, but no more frequently than once every six (6) months; b. Complete Mouth X-ray and Panoramic X-ray - as needed, but no more frequently than once every twenty-four (24) months; c. Prophylaxis - one every six (6) months; must be separated by six (6) full months; d. Fluoride Treatment - limited to one (1) each six (6) month period; e. Space Maintainers - limited to permanent teeth through age fifteen (15) years; and f. Sealants - covered up to age fourteen (14) years, every thirty-six (36) months. 2. Benefits are provided for restorative, endodontic, periodontic, and surgical dental services, as indicated below, and are limited to two thousand dollars and zero cents (\$2,000.00) each calendar year. <ol style="list-style-type: none"> a. Amalgam, Silicate, Sedative and Composite Resin Fillings including the replacement of an existing restoration; b. Stainless steel crowns to posterior and anterior teeth; c. Porcelain crowns to anterior teeth only; d. Simple extraction; e. Extraction of an impacted tooth; f. Pulpotomy, pulpectomy, and root canal; and g. Gingivectomy, gingivoplasty, and gingival curettage. <p>Other Dental Services (The calendar year maximum does not apply to these services.)</p> <ol style="list-style-type: none"> 1. Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled Child is covered under the program. Injury to teeth as a result of chewing or biting is not considered an accidental injury. 2. Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled Child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center, or dental office. These services must be pre-certified.
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| | <p>3. No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. Diagnosis and surgical treatment for temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a practitioner or dentist, is subject to a lifetime maximum benefit of five thousand dollars and zero cents (\$5,000.00) per Member. This lifetime maximum will apply regardless of whether the temporomandibular/craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.</p> |
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Covered Service	Description
<p>DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to Children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to Children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP Children. (Section 2103(b)(5) of the Social Security Act)</p>	<p>State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:</p> <ol style="list-style-type: none"> 1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule). 2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule). 3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999). 4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999). 5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999). 6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999). 7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999). 8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999). 9. Emergency Dental Services. <p>Periodicity Schedule. The State has adopted the American Academy of Pediatric Dentistry periodicity schedule. See Table B for CHIP Dental Covered Services.</p>
<p>Inpatient substance abuse treatment services and residential substance abuse treatment services. (Section 2110(a)(18) of the Social Security Act)</p>	<p>Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse, as follows:</p> <ol style="list-style-type: none"> 1. Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential substance abuse treatment. 2. Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse. 3. Certification of medical necessity by the Contractor's UM program is required for admissions to a hospital or residential treatment center. 4. Benefits for substance abuse do not include services for treatment of nervous and mental conditions.
<p>Outpatient substance abuse treatment services. (Section 2110(a)(19) of the Social Security Act)</p>	<ol style="list-style-type: none"> 1. Benefits are provided for covered medical expenses for medically necessary intensified outpatient programs in a hospital, an approved licensed alcohol abuse or chemical dependency facility, or an approved drug abuse treatment facility. 2. Benefits are provided for covered medical expenses for substance abuse treatment while not confined as a hospital inpatient. 3. Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

Covered Service	Description
Care management services. (Section 2110(a)(20) of the Social Security Act)	<p>Medical Care Management may be performed by the UM program for those Children who have a catastrophic or chronic condition.</p> <p>Through medical Care Management, the UM program may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and supplies which are not otherwise covered. The decision to provide extended or alternative benefits is made on a case-by-case basis to covered Children who meet the UM program's criteria then in effect. Any decision regarding the provision of extended or alternative benefits is made by the UM program.</p>
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders. (Section 2110(a)(22) of the Social Security Act)	<p>Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the Member's practitioner and provided by a licensed physical therapist.</p> <p>Benefits are provided for medically necessary occupational therapy services prescribed by the Member's practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist.</p> <p>Benefits are provided for medically necessary speech therapy services prescribed by the Member's practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech, delayed language development, or articulation disorders.</p> <p>Benefits are provided for an annual hearing examination, if indicated by the results of a hearing screening.</p>
Hospice care (concurrent, in the case of an individual who is a child, with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made). (Section 2110(a)(23) of the Social Security Act)	<p>Benefits are provided for inpatient and home hospice services, subject to UM requirements. Benefits for hospice services are limited to an overall lifetime maximum of fifteen thousand dollars and zero cents (\$15,000.00).</p>

<p>Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24) of the Social Security Act) (See instructions)</p>	<p>Benefits may be provided in a facility, home, school, or other setting if recognized by State law and only if the service is prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law, performed under the general supervision or at the direction of the physician, or furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of license.</p> <p>Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered.</p> <p>Transplant Benefits:</p> <ol style="list-style-type: none"> 1. Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies: <ol style="list-style-type: none"> a. The Member or Provider obtains prior approval from the Contractor's UM program; b. The condition is life-threatening; c. Such transplant for that condition is the subject of an ongoing phase III clinical trial;
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	<p>d. Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, Federal agency or other such organization recognized by medical specialists who have appropriate expertise; and</p> <p>e. The Member is a suitable candidate for the transplant under the medical protocols used by the Contractor's UM program.</p> <p>2. In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure.</p> <p>3. Benefits are provided for transportation costs of recipient and two other individuals to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of two (2) individuals at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two (2) other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to ten thousand dollars and zero cents (\$10,000.00).</p> <p>4. If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:</p> <p>a. The following expenses are covered:</p> <ul style="list-style-type: none"> • A search for matching tissue, bone marrow, or organ. • Donor's transportation. • Charges for removal, withdrawal, and preservation. • Donor's hospitalization. <p>b. When only the recipient is a Member in the program, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the recipient's contract.</p> <p>c. When both the recipient and the donor are enrolled in the program, the donor is entitled to benefits under the donor's contract.</p> <p>d. When only the donor is a Plan participant, the donor is not entitled to donor coverage benefits. No benefits are provided to the non-member transplant recipient.</p>
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	<p>e. If any organ or tissue is sold rather than donated to the Member, no benefits are payable for the purchase price of such organ or tissue.</p> <p>Manipulative therapy is a covered medical expense but benefits shall not exceed two thousand dollars and zero cents (\$2,000.00) annually.</p> <p>Benefits are provided for Medically Necessary Services and supplies required for the treatment of injury or disease of the eye which fall within the legal scope of practice of a licensed optometrist. Benefits are provided for annual routine eye examinations, eyeglasses, and the fitting of eyeglasses.</p> <p>Benefits are provided for diabetes self-management training and education, including medical nutrition therapy, for the treatment of diabetes, subject to a limitation of two hundred fifty dollars and zero cents (\$250.00) per Benefit Period.</p>
Medical transportation. (Section 2110(a)(26) of the Social Security Act)	Professional ambulance services to the nearest hospital, which is equipped to handle the Member's condition in connection with covered hospital inpatient, care; or when related to and within seventy-two (72) hours after accidental bodily injury or medical emergency whether or not inpatient care is required.

<p>Limitations and Exclusions:</p>	<ol style="list-style-type: none"> 1. For convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician for an Member who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; benefits shall not be provided if the Member was admitted to a hospital for his or her own convenience or the convenience of his or her physician, or that the care or treatment provided did not relate to the condition for which the enrolled Child was hospitalized, or that the hospital stay was excessive for the nature of the injury or illness, it being the intent to provide benefits only for the services required in relation to the condition for which the enrolled Child was hospitalized and then only during such time as such services are medically necessary. 2. For cosmetic purposes, except for correction of defects incurred by the Member while covered under the program through traumatic injuries or disease requiring surgery. 3. For sex therapy or marriage or family counseling. 4. For custodial care, including sitters and companions. 5. For equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, etc.). 6. For procedures, which are experimental/investigative in nature. 7. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic Complaints of the feet. 8. For services and supplies related to infertility, artificial insemination, intrauterine insemination, and in vitro fertilization regardless of any claim to be medically necessary. 9. For services which the Contractor's UM program determines are not medically necessary for treatment of injury or illness. 10. For services provided under any Federal, state, or governmental plan or law including but not limited to Medicare except when so required by Federal law. 11. For nursing or personal care facility services i.e., extended care facility, nursing home, or personal care home, except as specifically described elsewhere. 12. For treatment or care for obesity or weight control including diet treatment, gastric or intestinal bypass or stapling, or related procedures regardless of any claim of medical necessity or degree of obesity. 13. For inpatient rehabilitative services consisting of the combined use of medical, social, educational, or vocational services, or any such services designed to enable Members disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by the Contractor's UM program. 14. For outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable Members disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of treatment prescribed by the Member's physician and provided by a licensed therapist. 15. For care rendered by a Provider, (physician or other Provider) who is related to the covered Member by blood or marriage or who regularly resides in the enrolled Child's household. 16. For services rendered by a Provider not practicing within the scope of his license at the time and place service is rendered.
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Covered Service	Description
	<ol style="list-style-type: none"> 17. For treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease. 18. For reversal of sterilization regardless of claim of medical necessity. 19. For elective abortion unless documented to be medically necessary in order to preserve the life or physical health of the mother. 20. For charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain Medical Records or information required to adjudicate a claim. 21. For travel, whether or not recommended by a physician, except as provided for under transplant benefits. 22. Because of diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war. 23. For treatment of any injury arising out of or in the course of employment or any sickness entitling the Member to benefits under any Workers' Compensation or Employer Liability Law. 24. For any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the Member is unable to recover from the responsible party, benefits shall be provided. 25. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea.

Table B. CHIP Dental Covered Services

Dental procedures not listed within Table B are not Covered Services under the CHIP. Members are subject to a two thousand dollars and zero cents (\$2,000.00) annual maximum.

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D0120	PERIODIC ORAL EVALUATION	YES	0	19	1 EVERY 6 MONTHS	NO
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	YES	0	19	N/A	NO
D0145	ORAL EVALUATION FOR MEMBER UNDER 3	YES	0	3	1 EVERY 6 MONTHS	NO
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED MEMBER	YES	0	19	1 EVERY 6 MONTHS	NO
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	YES	0	19	1 EVERY 24 MONTHS	NO
D0220	INTRAORAL-PERIAPICAL-FIRST FILM	YES	0	19	N/A	NO
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	YES	0	19	N/A	NO
D0240	INTRAORAL-OCCLUSAL FILM	YES	0	19	N/A	NO
D0270	BITEWING-SINGLE FILM	YES	0	19	1 EVERY 6 MONTHS	NO
D0272	BITEWINGS-TWO FILMS	YES	0	19	1 EVERY 6 MONTHS	NO
D0273	BITEWINGS - THREE FILMS	YES	0	19	1 EVERY 6 MONTHS	NO

D0274	BITEWINGS-FOUR FILMS	YES	0	19	1 EVERY 6 MONTHS	NO
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	³ SEE TMJ DISORDER BENEFIT	0	19	³ SEE TMJ DISORDER BENEFIT	YES
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS, BY REPORT	³ SEE TMJ DISORDER BENEFIT	0	19	³ SEE TMJ DISORDER BENEFIT	YES
D0330	PANORAMIC FILM	YES	0	19	1 EVERY 24 MONTHS	NO
D1110	PROPHYLAXIS-ADULT - AGE 14+	YES	14	19	1 EVERY 6 MONTHS	NO
D1120	PROPHYLAXIS-CHILD - AGE 0 -13	YES	0	13	1 EVERY 6 MONTHS	NO
D1208	TOPICAL APPLICATION OF FLUORIDE	YES	0	19	1 EVERY 6 MONTHS	
D1351	SEALANT - PER TOOTH	YES	0	14	1 EVERY 36 MONTHS MOLARS ONLY	NO
D1510	SPACE MAINTAINER - FIXED - UNILATERAL	YES	0	15	PERMANENT TEETH ONLY	NO
D1515	SPACE MAINTAINER - FIXED - BIILATERAL	YES	0	15	PERMANENT TEETH ONLY	NO

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D1520	SPACE MAINTAINER - REMOVABLE UNILATERAL	YES	0	15	PERMANENT TEETH ONLY	NO
D1525	SPACE MAINTAINER - REMOVABLE BILATERAL	YES	0	15	PERMANENT TEETH ONLY	NO
D1550	RECEMENTATION OF SPACE MAINTAINER	YES	0	15	N/A	NO
D1555	REMOVAL OF FIXED SPACE MAINTAINER	YES	0	15	N/A	NO
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2330	RESIN BASED COMPOSITE-ONE SURFACE, ANTERIOR	YES	0	19	N/A	NO
D2331	RESIN BASED COMPOSITE-TWO SURFACES, ANTERIOR	YES	0	19	N/A	NO
D2332	RESIN BASED COMPOSITE-THREE SURFACES, ANTERIOR	YES	0	19	N/A	NO
D2335	RESIN BASED COMPOSITE-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE	YES	0	19	N/A	NO

D2391	RESIN BASED COMPOSITE-ONE SURFACE, POSTERIOR	YES	0	19	N/A	NO
D2392	RESIN BASED COMPOSITE-TWO SURFACES, POSTERIOR	YES	0	19	N/A	NO
D2393	RESIN BASED COMPOSITE-THREE SURFACES, POSTERIOR	YES	0	19	N/A	NO
D2394	RESIN BASED COMPOSITE-FOUR OR MORE SURFACES POSTERIOR	YES	0	19	N/A	NO
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	YES	0	19	1 EVERY 5 YRS ANTERIOR TEETH ONLY	YES
D2751	CROWN-PORCELAIN FUSED TO	YES	0	19	1 EVERY 5 YRS	YES

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
	PREDOMINANTLY BASE METAL				ANTERIOR TEETH ONLY	
D2930	PREFABRICATED STAINLESS STEEL CROWN- PRIMARY TOOTH	YES	0	19	N/A	NO
D2931	PREFABRICATED STAINLESS STEEL CROWN- PERMANENT TOOTH	YES	0	19	N/A	YES
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	YES	0	19	ANTERIOR TEETH ONLY	NO
D2940	SEDATIVE FILLING	YES	0	19	N/A	NO
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	YES	0	19	N/A	NO
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	YES	0	19	N/A	NO
D3230	PULPAL THERAPY (RESORBABLE FILLING)	YES	0	6	N/A	NO
D3240	PULPAL THERAPY (RESORBABLE FILLING) POSTERIOR PRIMARY TOOTH	YES	0	10	N/A	NO

D3310	ANTERIOR (EXCLUDING FINAL RESTORATION)	YES	0	19	1 PER LIFETIME PER TOOTH	PRE-AUTH & RETRO REVIEW
D3320	BICUSPID (EXCLUDING FINAL RESTORATION)	YES	0	19	1 PER LIFETIME PER TOOTH	PRE-AUTH & RETRO REVIEW
D3330	MOLAR (EXCLUDING FINAL RESTORATION)	YES	0	19	1 PER LIFETIME PER TOOTH	PRE-AUTH & RETRO REVIEW
D4210	GINGIVECTOMY OR GINGIVOPLASTY -FOUR OR MORE CONTIGUOUS TEETH	YES	0	19	1 EVERY 36 MONTHS	YES
D4211	GINGIVECTOMY OR GINGIVOPLASTY- 1 TO 3 TEETH PER QUADRANT	YES	0	19	1 EVERY 36 MONTHS	YES
D4341	PERIODONTAL SCALING AND ROOT PLANING- FOUR OR MORE TEETH, PER QUADRANT	YES	10	19	2 QUADS PER VISIT 4 QUADS PER YEAR	YES
D4342	PERIODONTAL SCALING AND ROOT PLANING- ONE TO THREE TEETH, PER QUADRANT	YES	10	19	2 QUADS PER VISIT 4 QUADS PER YEAR	YES
D5110	COMPLETE UPPER	¹ SEE ACCIDENTAL	0	19	¹ SEE ACCIDENTAL	YES

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
		INJURY BENEFIT			INJURY BENEFIT	
D5120	COMPLETE LOWER	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D5211	UPPER PARTIAL-RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D5212	LOWER PARTIAL-RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D5213	UPPER PARTIAL-CAST METAL FRAMEWORK WITH RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D5214	LOWER PARTIAL-CAST METAL FRAMEWORK WITH RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7140	EXTRACTION, ERUPTED OR EXPOSED TOOTH (ELEVATION AND/OR FORCEPS REMOVAL)	YES	0	19	1 PER LIFETIME PER TOOTH	NO
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	YES	0	19	1 PER LIFETIME PER	NO

D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7241	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7270	TOOTH REPLANTATION AND/OR STABILIZATION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7780	FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7810	OPEN REDUCTION OF DISLOCATION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D7820	CLOSED REDUCTION OF DISLOCATION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7830	MANIPULATION UNDER ANESTHESIA	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7840	CONDYLECTOMY	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7850	SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7860	ARTHROTOMY	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7870	ARTHROCENTESIS	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES

D9220	DEEP SEDATION- GENERAL ANESTHESIA- FIRST 30 MINUTES	YES	0	19	² WHEN CLINICALLY NECESSARY	YES
D9221	DEEP SEDATION- GENERAL ANESTHESIA- EACH ADDITIONAL 15 MINUTES	YES	0	19	² WHEN CLINICALLY NECESSARY	YES
D9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE	YES	0	7	ALLOWABLE WITH RESTORATIVE PROCEDURES ONLY 1 PER VISIT/DAY	NO
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN	YES	0	19	N/A	NO
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN	YES	0	19	N/A	NO
D9951	OCCLUSAL ADJUSTMENT - LIMITED	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES

Notes:

1. ACCIDENTAL INJURY BENEFIT - THE CALENDAR YEAR MAXIMUM DOES NOT APPLY TO THESE SERVICES

Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the Member is covered under the plan. Injury to teeth as a result of chewing or biting is not considered accidental injury. **FOR ACCIDENTAL INJURY BENEFITS – SUBMIT A TREATMENT PLAN WITH PROCEDURE CODES FOR PRE-AUTHORIZATION APPROVAL.**

No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. **FOR ORTHODONTIC BENEFITS – SUBMIT A TREATMENT PLAN WITH PROCEDURE CODES FOR PRE-AUTHORIZATION APPROVAL.**

2. ANESTHESIA BENEFITS

Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the Member requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center, or dental office.

3. TMJ COVERAGE BENEFIT

Benefits are provided for diagnosis and surgical treatment of temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a Practitioner or dentist, subject to a lifetime maximum benefit of five thousand dollars and zero cents (\$5,000.00) per Member. This lifetime maximum will apply regardless of whether the temporomandibular – craniomandibular joint disorder was caused by an accidental injury or was congenital in nature. **FOR TMJ BENEFITS – SUBMIT A TREATMENT PLAN WITH PROCEDURES FOR PRE-AUTHORIZATION APPROVAL.**

EXHIBIT C: EXTERNAL QUALITY REVIEW

Section 1932(c)(2) of the Act requires states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including, but not limited to, the evaluation of quality outcomes, timeliness, network adequacy, and access to services. The requirements for External Quality Review (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. Pursuant to Section 2103(f) of the Act and this Contract, such requirements apply to the Contractor. The EQR will consist of the mandatory activities, and may include the optional activities, described in 42 C.F.R. §438.358.

The results of the EQR are made available, upon request, to 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 UM systems, and program oversight. The Division requires that the Contractor:

1. Actively participate in planning and developing the measures to be utilized with the Division and the EQRO. The Contractor's quality leadership team will be given an opportunity to provide input into the measures to be utilized;
2. Accurately, completely, and within the required time frame identify eligible Members to the EQRO;
3. Ensure the appropriate technical specifications (CHIPRA and the Division) are used for the calculation of each performance measure.
4. Correctly identify and report the numerator and denominator for each measure;
5. Actively encourage and require Providers, including Subcontractors, to provide complete and accurate Provider Medical Records within the time frame specified by the EQRO;
6. Demonstrate how the results of the EQR are incorporated into the Contractor's overall QM program and demonstrate progressive improvements during the term of the Contract;
7. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made;
8. Develop a monitoring strategy for assessing the quality of encounter data;
9. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Parts 433 and 438; and
10. Ensure that data, clinical records, and workspace located at the Contractor's work site

are available to the independent review team and to the Division, upon request.

EXHIBIT D: MEDICAL LOSS RATIO (MLR) REQUIREMENTS

The Contractor is required to rebate a portion of the Capitation Payment to the Division in the event the Contractor does not meet the eighty-five percent (85%) minimum MLR standard. This Exhibit describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention 4) payment of any rebate due to the Division, and 5) liquidated damages that may be assessed against the Contractor for failure to meet requirements.

A. Reporting Requirements

1. General Requirements

For each MLR Reporting Quarter and Year, the Contractor must submit to the Division a report which complies with the requirements that follow concerning Capitation Payments received and expenses related to CHIP Members (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 April 1 of the year following the end of an MLR Reporting Year, in a format and in the manner prescribed by the Division.

The report for each MLR Reporting Quarter must be submitted to the Division by the sixtieth (60th) calendar day following the end of the MLR Reporting Quarter, in a format and in the manner prescribed by the Division.

3. 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.

4. Additional Reporting

During each MLR Reporting Year, Contractor must submit the following additional reports to the Division in a manner that meets the definition of 42 C.F.R. § 438.8 (k) at the time of the submission of the Annual MLR Report:

- a. Total incurred claims
- b. Expenditures on quality improving activities
- c. Expenditures related to activities compliant with 42 C.F.R. Sections § 438.608(a)(1) through (5), (7), (8) and (b)

- d. Non-claims costs
- e. Premium revenue
- f. Taxes, licensing and regulatory fees
- g. Methodology(ies) for allocation of expenditures
- h. Any credibility adjustment applied
- i. Supporting schedules/documentation for any adjustments made to items a-h.
- j. Reconciling supplemental schedule(s) supporting the amounts claimed for all third parties (including related parties) and/or sub-capitated vendors included in amounts reported on the MLR Report for items a-i. Obtained in accordance with the requirements of 42 C.F.R. Section §438.8(k)(3)
- k. The Calculated MLR
- l. Any remittance owed to the State
- m. A comparison of the information reported in the MLR Report to the Audited Financial Statement
- n. A description of the aggregation method used
- o. The number of Member Months

5. Attestation

Contractor must attest to the accuracy of the calculation of the MLR in accordance with the requirements of 42 C.F.R. Section 438.8(n) when submitting reports required under this section.

6. Recalculation of MLR

In any instance where the State makes a retroactive change to the Capitation Payments for a MLR Reporting Year where the MLR Report has already been submitted to the State, Contractor must re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new MLR Report meeting the requirements of this section. Refer to 42 C.F.R. Section §438.8(m). Any recalculated MLR Report identified in this section must be provided to the State no later than sixty (60) days after the reported retroactive change has been provided by the State.

B. Reimbursement for Clinical Services Provided to Members

The MLR Report must include direct claims paid to or received by Providers (including under capitated contracts with Network Providers), whose services are covered by the Subcontract for clinical services or supplies covered by the Division's Contract with the Contractor. Reimbursement for clinical services as defined in this section is referred to as "incurred claims."

1. Specific requirements include:
 - a. Unpaid claims liabilities for the MLR Reporting Year, including claims reported that are in the process of being adjusted or claims incurred but not reported;
 - b. Withholds from payments made to network Providers;
 - c. Claims that are recoverable for anticipated coordination of benefits;
 - d. Claims payments recoveries received as a result of subrogation;
 - e. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;
 - f. Changes in other claims-related reserves; and
 - g. Reserves for contingent benefits and the medical claim portion of lawsuits.
 - h. Identify and reduce incurred expenses by all realizable rebates or discounts available.
2. Amounts that must be deducted from incurred claims include:
 - a. Overpayment recoveries received from Network Providers
 - b. Prescription drug rebates received and accrued;
3. Expenditures that must be included in incurred claims include:
 - a. The amount of incentive and bonus payments made, or expected to be made, to Network Providers;
 - b. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph 42 C.F.R. §438.8(e)(4);
4. Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.
5. Amounts that must be excluded from incurred claims:
 - a. Non-claims Costs, as defined in this Contract, which include amounts paid to

third party vendors for secondary network savings; amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management; amounts paid, including amounts paid to a Provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 C.F.R. §438.3(e) and §457.1201 and provided to a Member; and fines and penalties assessed by regulatory authorities.

- b. Amounts paid to the State as remittance under 42 C.F.R. §438.8(j).
- c. Amounts paid to network Providers under 42 C.F.R. §438.6(d).

C. Activities that Improve Health Care Quality

1. General Requirements

The MLR Report may include expenditures for activities that improve health care quality, as described in this section. The expenditures must meet the following requirements:

- a. An activity that meets the requirements of 45 C.F.R. § 158.150(b) and is not excluded under 45 C.F.R. § 158.150(c).
- b. An activity related to any EQR-related activity as described in 42 C.F.R. § 438.358(b) and (c).
- c. Any expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. § 158.151, and is not considered incurred claims.

2. Activity Requirements

Activities conducted by the Contractor to improve quality must meet the following requirements:

- a. The activity must be designed to:
 - i. Improve health quality;
 - ii. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
 - iii. Be directed toward individual Members or incurred for the benefit of

specified segments of Members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-Members;

- iv. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations;
- v. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations. Examples include the direct interaction of the Contractor (including those services delegated by Subcontract for which the Contractor retains ultimate responsibility under the terms of the Contract with the Division) with Providers and the Member or the Member's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
 - (a) Effective Care Management, Care Coordination, chronic disease management, and medication and care compliance initiatives including through the use of the Medical Homes model as defined in the section 3502 of PPACA;
 - (b) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
 - (c) 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. Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD-10 as the standard medical data code set, implementing ICD-10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA),⁴² U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.
- viii. Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

- (a) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help 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.
- ix. Improve patient safety, reduce medical errors, and lower infection and mortality rates. Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:
 - (a) The appropriate identification and use of best clinical practices to avoid harm;
 - (b) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;
 - (c) Activities to lower the risk of facility-acquired infections;
 - (d) Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions;
 - (e) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and
 - (f) Health information technology to support these activities.
- x. Implement, promote, and increase wellness and health activities. Examples of activities primarily designed to implement, promote, and increase wellness and health include, but are not limited to:
 - (a) Wellness assessments;

- (b) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
 - (c) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
 - (d) Public health education campaigns that are performed in conjunction with State or local health departments;
 - (e) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS (Public Health Service) Act;
 - (f) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
 - (g) Coaching or education programs and health promotion activities designed to change Member behavior and conditions (for example, smoking or obesity); and,
 - (h) Health information technology to support these activities.
- xi. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with 45 C.F.R. Section § 158.151.

3. Exclusions

Expenditures and activities that must not be included in quality improving activities are:

- a. Those that are designed primarily to control or contain costs;
- b. The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;
- c. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;
- d. Those activities that can be billed or allocated by a Provider for care delivery and

which are, therefore, reimbursed as clinical services;

- e. Those that are for establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended;
- f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
- g. All retrospective and concurrent utilization review;
- h. Fraud prevention activities;
- i. The cost of developing and executing Provider contracts and fees associated with establishing or managing a Provider Network, including fees paid to a vendor for the same reason;
- j. Provider credentialing;
- k. Marketing expenses;
- l. Costs associated with calculating and administering individual Member or employee incentives;
- m. That portion of prospective utilization that does not meet the definition of activities that improve health quality; and
- n. Any function or activity not expressly included in paragraph one (1) or two (2) of this section, unless otherwise approved by and within the discretion of the Division, upon adequate showing by the Contractor that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

D. Activities Related to External Quality Review

1. General rule. The State, its agent that is not a Contractor or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.
2. Mandatory activities. For each Contractor and PIHP, the EQR must use information from the following activities:
 - a. Validation of performance improvement projects required by the State to comply with requirements set forth in §438.240(b)(1) and that were underway during the preceding 12 months.

- b. Validation of Contractor or PIHP performance measures reported (as required by the State) or Contractor or PIHP performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in §438.240(b)(2).
 - c. A review, conducted within the previous 3-year period, to determine the Contractor's or PIHP's compliance with standards (except with respect to standards under §438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of §438.204(g).
- 3. Optional activities. The EQR may also use information derived during the preceding 12 months from the following optional activities:
 - a. Validation of Member Encounter Data reported by an Contractor or PIHP.
 - b. Administration or validation of consumer or Provider surveys of quality of care.
 - c. Calculation of performance measures in addition to those reported by an Contractor or PIHP and validated by an EQRO.
 - d. Conduct of performance improvement projects in addition to those conducted by a Contractor or PIHP and validated by an EQRO.
 - e. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.
- 4. Technical assistance. The EQRO may, at the State's direction, provide technical guidance to groups of Contractors or PIHPs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

E. Expenditures Related to Health Information Technology and Meaningful Use Requirements

1. General Requirements

Contractor may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in 45 C.F.R. Section § 158.150 and that are designed for use by the Contractor, health care Providers, or Members for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives

possible by doing one or more of the following:

- a. Making incentive payments to health care Providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services; as defined in 45 C.F.R. § 158.140
- b. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care Providers, including those not eligible for Medicare and Medicaid incentive payments;
- c. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
- d. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law
- e. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
- f. Advancing the ability of Members, Providers, the Contractor or other systems to communicate patient-centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic health records accessible by Members and appropriate Providers to monitor and document an individual patient's medical history and to support Care Management;
- g. Reformatting, transmitting or reporting data to national or international government-based health organizations, as may be required by the Division, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and,
- h. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

F. Non-Claims Costs

1. General Requirements

The MLR Report must include non-claims costs, which are those expenses for administrative services that are not: incurred claims (as defined in section B),

expenditures for activities that improve health care quality (as defined in section C) or licensing and regulatory fees or Federal and State taxes (as defined in section K).

2. Non-Claims Costs Other

The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation payments for clinical services to Members, or expenditures on quality improvement activities as defined above. Expenses for administrative services include the following:

- a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity;
- b. Loss adjustment expenses not classified as a cost containment expense;
- c. Workforce salaries and benefits;
- d. General and administrative expenses; and
- e. Community benefit expenditures.

Revenue and expenses for administrative services should exclude the Health Insurer Tax, any allocation for premium taxes and any other revenue based assessments.

Expenses for administrative services may include amounts that exceed a third party's costs (profit margin), but these amounts must be justified and consistent with prudent management and fiscal soundness requirements to be includable when these transactions are between related parties.

3. Limitation of Non-Claims Administrative Costs:

The following expenses are not allowable to be included in non-claims costs or for consideration by the Division's actuaries for capitation rate setting purposes:

- a. charitable contributions my by Contractor;
- b. any penalties or fines assessed against Contractor;
- c. any indirect marketing or advertising expenses of the Contractor, including but not limited to costs to promote the managed care plan, costs of facilities used for special events, and costs of displays, demonstrations, donations, and promotional items such as memorabilia, models, gifts, and souvenirs. The State may classify an item listed in this clause as an allowable administrative expense for rate-setting purposes, if the State determines that the expense is incidental to an activity related to state public health care programs that is an allowable cost for purposes of rate setting;
- d. any lobbying and political activities, events, or contributions;

e. administrative expenses related to the provision of services not covered under any state plan or waiver;

f. alcoholic beverages;

g. memberships in any social, dining, or country club or organization;

h. entertainment, including amusement, diversion, and social activities, and any costs directly associated with these costs, including but not limited to tickets to shows or sporting events, meals, lodging, rentals, transportation, and gratuities;

i. Bad Debts of the Contractor;

j. Liquidated Damages paid to the Division, the State, or any other entity;

k. Capital Expenditures- Expenditures for items requiring capitalization are unallowable– (Depreciation of these capital expenditures, and maintenance expenses, in accordance with GAAP, are allowable.);

l. Abnormal or mass severance pay where payments of salaries and wages or any benefit arrangements exceed two months of compensation;

m. Cost of unallowable financing expenses (interest, bond issuance, bond discounts, etc.) as determined by applying the principles included in CMS Publication 15.1 Chapter 2, interest expense;

n. Defense and Prosecution (of criminal proceedings, civil proceedings, and claims are generally unallowable) – Exceptions are costs relating to Contractors' obligation to identify, investigate, or pursue recoveries relating to suspected Fraud, Waste, or Abuse of providers or Subcontractors and the reasonable legal costs related to subrogation, third party recoveries and provider credentialing matters, if incurred directly in administration of the Contract;

o. Income Taxes (Federal, state, and local taxes) and State Franchise Taxes - (Other taxes are generally allowable);

p. Investment Management Costs;

- q. Proposal Costs;
- r. Rebates and Profit Sharing (Profit sharing or rebate arrangements between the Contractor and a Subcontractor resulting in fees or assessments which are not tied to specifically identified services that directly benefit the Contract are unallowable unless specifically allowed by Contract. This fee effectively becomes a form of profit payment or rebate.);
- s. Royalty Agreements (associated fees, payments, expenses, and premiums);
- t. Losses in excess of the remaining depreciable basis for the disposition of depreciable property;
- u. Costs in excess of what a reasonable or prudent buyer would pay for goods or services.

For the purposes of this subsection, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits.

Charitable contributions under clause (a) include payments for or to any organization or entity selected by the Contractor that is operated for charitable, educational, political, religious, or scientific purposes that are not related to medical and administrative services covered under and state plan.

G. Allocation of Expenses

1. General Requirements

Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

H. Description of the Methods Used to Allocate Expenses

1. General Requirements

The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, and

other non-claims costs resulting from Contractor activities in Mississippi. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

- a. Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the Contractor must provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses;
- b. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense; and,
- c. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, Capitation Payment ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

I. Third Party Delegated Vendors

Third party vendors providing claims adjudication activity services to Members are required to supply all underlying data to the Contractor within one hundred eighty (180) calendar days of the end of the MLR reporting period or within thirty (30) calendar days of such data being requested by the Contractor in accordance with the requirements of 42 C.F.R. § 438.8(k)(3). The Contractor should validate the cost allocation reported by third parties to ensure the MLR accurately reflects the breakdown of amounts paid to the vendor between incurred claims, activities to improve health care quality, and non-claims cost.

1. Sub-Capitated Vendors

The Contractor must report to the Division the total expenses incurred by the third-party vendor for clinical services provided to Members, activities that Improve Health Care Quality, activities related to external Quality review, expenditures related to Health Information Technology and Meaningful Use Requirements, and non-claims cost incurred by the sub-capitated vendors. The sub-capitated payments should be adjusted to reflect the aforementioned expenses to the third party. When the sub-capitation payments to the third-party vendor exceed third party vendor's actual costs, the excess (profit margin), should be considered administrative non-claim costs from non-related vendors. When these transactions occur between related parties, there must be justification that these higher costs are consistent with prudent management

and fiscal soundness policies to be included as allowable administrative non-claim costs.

2. Management Fee Arrangement

The Contractor is encouraged to report to the Division the total expenses incurred by the management organization for the plan. These costs should be adjusted for any non-allowable activities. In the absence of specific State guidance, the Contractor should refer to other Federal regulations concerning the identification of non-allowable costs.

J. Maintenance of Records

The Contractor must maintain and retain, and require Subcontractors to retain, as applicable, for a period of no less than ten (10) years, in accordance with 42 C.F.R. § 438.3(u) and §457.1201, and make available to the Division upon request the data used to allocate expenses reported, together with all supporting information required to determine that the methods identified and reported as required under this Exhibit C were accurately implemented in preparing the MLR Report.

K. Formula for Calculating Medical Loss Ratio

1. Medical Loss Ratio

- a. Contractor's MLR is the ratio of the numerator and the denominator, as defined:
 - i. The numerator of the Contractor's MLR for an MLR Reporting Year must equal: (1) the Contractor's incurred claims, plus (2) the Contractor's expenditures for activities that improve health care quality, plus (3) the Contractor's expenditures for fraud reduction activities (as discussed in subsection d below).
 - ii. The denominator of the Contractor's MLR for an MLR Reporting Year must equal the Contractor's Adjusted Premium Revenue. The Adjusted Premium Revenue is Premium Revenue minus the Contractor's Federal, State, and local taxes, licensing and regulatory fees (as defined in subsection c of this Section) any Liquidated Damages paid by contractor during the MLR Reporting Year, and is aggregated in accordance with subsection f below.
- b. A Contractor's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.
- c. Federal, State, and local taxes and licensing and regulatory fees. Taxes,

licensing and regulatory fees for the MLR Reporting Year include:

- i. Statutory assessments to defray the operating expenses of any State or Federal department.
- ii. Examination fees in lieu of premium taxes as specified by State law.
- iii. Federal taxes and assessments allocated to Contractor, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.
- iv. State and local taxes and assessments including:
 - (a) Any industry wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
 - (b) Guaranty fund assessments.
 - (c) Assessments of state or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by states.
 - (d) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
 - (e) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.
- v. Payments made by Contractor that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 C.F.R. §158.162(c), limited to the highest of either:
 - (a) Three percent (3%) of earned premium; or
 - (b) The highest premium tax rate in the State for which the report is being submitted, multiplied by Contractors earned premium in the State.
- d. Fraud Prevention Activities: The Contractor's expenditures on activities related to fraud prevention as adopted for the private market at 45 C.F.R. part 158. Such expenditures must not include expenses for fraud reduction efforts associated with "incurred claims" wherein the amount of claims payments recovered through fraud

reduction efforts, not to exceed the amount of fraud reduction expenses.

- e. **Credibility Adjustment:** The Contractor may add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Partially Credible. The Credibility Adjustment is added to the reported MLR calculation before calculating any remittance due. The Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is fully credible.
- f. **Aggregation of Data:** Contractor will aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.
- 1. **Rebating Capitation Payments if the eighty-five percent (85%) Medical Loss Ratio Standard is Not Met**

- a. **General Requirement**

For each MLR Reporting Year, the Contractor must provide a rebate to the Division if the Contractor's MLR does not meet or exceed the eighty-five percent (85%) minimum requirement.

- b. **Amount of Rebate**

For each MLR Reporting Year, the Contractor must rebate to the Division the difference between the total amount of Adjusted Premium Revenue received by the Contractor from the Division multiplied by the required minimum MLR of eighty-five percent (85%) and the Contractor's actual MLR.

- c. **Timing of Rebate**

The Contractor must provide any rebate owing to the Division no later than May 1 following the year after the MLR Reporting Year.

- d. **Late Payment Interest**

If Contractor fails to pay any rebate owing to the Division in accordance within the time periods set forth in this Exhibit, then, in addition to providing the required rebate to the Division, Contractor must pay the Division interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher, on the total amount of the rebate, accruing from May 1.

EXHIBIT E: MEMBER COMPLAINT, GRIEVANCE, APPEAL AND INDEPENDENT EXTERNAL REVIEW PROCESS

A. General Requirement

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 an Independent External Review.
4. Maintaining written documentation of each Complaint, Grievance, Appeal, and the actions taken by the Contractor.
5. Distributing a written description and educating Network Providers of the Contractor's Grievance and Appeal process and how Providers can submit a Grievance or Appeal for a Member, or on their own behalf.
6. Making available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
7. Designating a specific individual as the Contractor's CHIP Member Grievances and Appeals coordinator with the authority to administer the policies and procedures for resolution of a Grievance or Appeal, to review patterns/trends in Grievances and Appeals, and to initiate corrective action.
8. Ensuring that the individuals who make decisions on Grievances or Appeals are not involved in any previous level of review or decision-making nor a subordinate of any such individual. 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. 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.
13. The following parties have a right to file a Grievance and Appeal on behalf of the Member:
 - a. The legal guardian of the Member for a minor or an incapacitated adult,
 - b. A representative of the Member as designated in writing to the Contractor, or
 - c. A service Provider acting on behalf of the Member and with the Member's written consent.
13. All notices sent to Members must comply with 42 C.F.R. § 438.404(a). Notices indicating the resolution of Grievances must be in writing and must meet the language and format requirements of 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding. The notice must explain the following:
 - a. Adverse Benefit Determination the Contractor has taken or intends to take (e.g., resolution of the Grievance or Appeal).
 - b. Reasons for the Adverse Benefit Determination (e.g., findings and conclusions based on the investigation, all information considered in investigating the Grievance or Appeal).
 - c. Member's or the Provider's right to file an Appeal with the Contractor.
 - d. Procedures for exercising Appeal rights.
 - e. Circumstances under which Expedited Resolution is available and how to request it.

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

14. Notices indicating the resolution of Appeals must be in writing and must meet the language and format requirements of 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding. The notice must explain the following:

- a. Adverse Benefit Determination the Contractor has taken or intends to take (e.g., resolution of the Grievance or Appeal).
- b. Reasons for the Adverse Benefit Determination (e.g., findings and conclusions based on the investigation, all information considered in investigating the Grievance or Appeal).
- c. Member's right to request an Independent External Review.
- d. Procedures for exercising Independent External Review rights.
- e. Member's right to have benefits continue pending resolution of the Independent External Review, how to request that benefits be continued, and circumstances under which the Member may be required to pay the costs of these services.

B. Complaint

An expression of dissatisfaction received orally that is of a less serious or formal nature that is resolved within one (1) calendar day of receipt. Any Complaint not resolved within one (1) calendar 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 or Authorized Representative 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) calendar day of receipt which 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) calendar 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 Adverse Benefit Determination as defined in this Contract. A Grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness or a Provider or an employee, or failure to respect the Members rights.

A Member or Authorized Representative may file a Grievance either orally or in writing with the Contractor at any time after the event causing the dissatisfaction.

Within five (5) calendar 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) calendar days of the decision to extend the time frame.

Upon resolution of the Grievance, the Contractor shall mail a resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred above, unless the resolution of the Grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the Grievance.

D. Appeal

A request for review by the Contractor of a Contractor Action or Adverse Benefit Determination.

A Member or Authorized Representative may file an Appeal either orally or in writing of an Adverse Benefit Determination a Contractor Action or Adverse Benefit Determination within sixty (60) calendar days of receiving the Contractor's notice of Action or Adverse Benefit Determination. The Contractor shall consider the Member, Authorized Representative, or estate representative of a deceased Member as parties to the Appeal.

The Contractor has thirty (30) calendar days from the date the initial verbal or written Appeal is received by the Contractor to resolve the Appeal, or as expeditiously as the Member's health condition requires. The Contractor shall appoint at least one (1) person to review the Appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision. Within this same thirty (30) calendar 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 or Adverse Benefit Determination is treated as an Appeal (to establish the earliest possible filing date for the Appeal). A verbal Appeal shall be followed by a written Appeal that is signed by the Member 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 thirty (30) calendar day time frame by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two (2) calendar days of the decision to extend the time frame.

The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

The Contractor shall provide the Member or the representative the opportunity, before and during the Appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the Appeals process. The Contractor shall include as parties to the Appeal the Member and 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 or Adverse Benefit Determination. Timely filing means within ten (10) days of the Contractor notice of Action or Adverse Benefit Determination) or the Member asks for an Independent External Review within one hundred twenty (120) calendar days from the date on the Contractor notice of Action or Adverse Benefit Determination;
1. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
2. The services were ordered by an authorized service Provider;

3. The time period covered by the original authorization has not expired; and
4. 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 an Independent External Review or taken any further Action;
3. The Independent External Vendor issues an Independent External Review 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 or Adverse Benefit Determination is upheld, the Contractor may recover the cost of the services furnished to the Member while the Appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 C.F.R. § 431.230(b).

If the Contractor or the Independent External Vendor reverses a decision to deny, limit, or delay services, and these services were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination. If the Contractor or the Independent External Vendor 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 or Adverse Benefit Determination.

The Contractor shall establish and maintain an expedited review process for Appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Such a determination is based on:

1. A request from the Member;
2. A Provider's support of the Member's request;
3. A Provider's request on behalf of the Member; or

4. The Contractor's independent determination.

The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.

The Contractor shall resolve the Appeal within seventy-two (72) hours of receipt of the request for an expedited Appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document verbal notice.

The Contractor may extend the time frame by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.

The Contractor shall ensure that punitive Action is not taken against a Member or a service Provider who requests an Expedited Resolution or supports a Member's expedited Appeal. The Contractor shall provide an Expedited Resolution, if the request meets the definition of an expedited Appeal, in response to a verbal or written request from the Member or service Provider on behalf of the Member.

The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.

If the Contractor denies a request for an Expedited Resolution of an Appeal, it shall:

1. Transfer the Appeal to the thirty (30) calendar day time frame for standard resolution, in which the thirty (30) calendar day period begins on the date the Contractor received the original request for Appeal; and
2. Make reasonable efforts to give the Member prompt verbal notice of the denial, and follow up with a written notice within two (2) calendar days.

The Contractor shall document in writing all verbal requests for Expedited Resolution and shall maintain the documentation in the case file.

F. Independent External Review

A review of any Adverse Benefit Determination conducted by the State or a contractor other than the contractor responsible for the matter subject to external review shall be in accordance with 42 C.F.R. §457.1150.

A Member or Authorized Representative may request an Independent External Review if he or she is dissatisfied with an Action or Adverse Benefit Determination that has been taken by the Contractor within one hundred twenty (120) calendar days of the notice of Appeal

resolution by the Contractor. The Member must exhaust all Contractor level Appeal procedures prior to requesting an Independent External Review.

For Member Appeals, the Contractor is responsible for providing to the Member an Appeal summary describing the basis for the denial. For standard Appeals, the Appeal summary must be submitted to the Member at least ten (10) calendar days prior to the date of the review. For expedited Appeals, (that meet criteria set forth in 42 C.F.R. § 438.410 the Appeal summary must be faxed or overnight mailed to the Member, as expeditiously as the Member's health condition requires, but no later than four (4) business hours after the Independent External Review Vendor informs the Contractor of the expedited Appeal. The External Independent Review Vendor 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 Contractor 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 Independent External Review requirements of the State and Federal Medicaid law in regard to an Action or Adverse Benefit Determination taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.

The Contractor shall educate its Members of their right to Appeal directly to the Independent External Review Vendor. The Member must exhaust all Contractor level Grievance and Appeal procedures prior to requesting an Independent External Review with the Vendor.

Any Adverse Action, Adverse Benefit Determination or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's Authorized Representative to the Contractor for an Independent External Review conducted in accordance with 42 C.F.R. § 457.1250. Adverse Action and Adverse Benefit Determination include reductions in service, suspensions, terminations, and denials. Furthermore, the Contractor's denial of payment for Mississippi Medicaid covered services and failure to act on a request for services within required time frames may also be appealed. Appeals must be requested in writing by the Member or the Member's representative within one hundred twenty (120) calendar days of the Member's receipt of notice of Adverse Action or Adverse Benefit Determination unless an acceptable reason for delay exists. An acceptable reason shall include, but not be limited to, situations or events where:

1. Appellant was seriously ill and was prevented from contacting the Contractor;
2. Appellant did not receive notice of the Contractor's decision;
3. Appellant sent the request for Appeal to another government agency in good faith within the time limit; and
4. Unusual or unavoidable circumstances prevented a timely filing.

The Contractor shall comply with the Independent External Review decision. The Independent External Review Vendor's decision in these matters shall be final and shall not be subject to Appeal by the Contractor.

EXHIBIT F: CHIP QUALITY MANAGEMENT

A. General Requirements

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 Mississippi CHIP 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.

B. Improvement Plan

The Contractor must submit to the Division for approval an improvement plan, as determined by the Division, and within time frames established by the Division, to resolve any performance or quality of care deficiencies identified by the Division.

The Division must approve the improvement plan. Failure by the Contractor to comply with requirements and improvement actions requested by the Division may result in the application of liquidated damages.

C. Standard I

The scope of the QM program must be comprehensive in nature, and support the ability of Mississippi CHIP 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 all 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, and/or 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/Substance Use Disorder and physical health services;
 - v. Continuity of care;
 - vi. Behavioral Health Services/Substance Use Disorder; and
 - vii. Inpatient hospitalization.

- 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;
 - 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.

D. 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 Mississippi CHIP 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;
 - iv. Meets at least quarterly, and otherwise as needed; and
 - v. 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.

E. 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 Well-Baby and Well-Child

- Care Services;
 - c. Division-defined clinical areas;
 - d. Care Management Related Clinical Outcomes and Performance;
 - e. Behavioral Health/Substance Use Disorder;
 - f. Maternity; and
 - g. Inpatient discharge planning.
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.

F. 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.

G. 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 on behalf of the Contractor.
6. Ensure the delegated entity adheres to the standards of the current Contract.

H. 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.

I. Standard VII

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.

J. Standard VIII

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 onsite evaluations.

EXHIBIT G: REPORTING REQUIREMENTS

This Exhibit (Table C) is provided for reference only within this Contract. This Exhibit does not include all of the required reports and Deliverables under this Contract.

Table C. Reporting Requirements

Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Section	Primary Applicable Contract Section Name
1	Monthly	1-A-1	Unduplicated Number of Newly Enrolled Members in Care Management Program	8-A	Care Management Responsibilities
1	Monthly	1-A-2	Unduplicated Number of Disenrolled Care Management Members	8-A	Care Management Responsibilities
1	Monthly	1-A-3	Unduplicated Number of Members Contacted for Purposes of Care Management	8-A	Care Management Responsibilities
1	Monthly	1-A-4	Number of Successful Care Management Contacts	8-A	Care Management Responsibilities
1	Monthly	1-A-5	Health Risk Assessment (HRA)	8-A-1	Assignment of Risk Levels
1	Monthly	1-A-6	Adult Physical Exams	8-A	Care Management Responsibilities

1	Monthly	1-B-1	Unduplicated Number of Newly Enrolled Members in Medical Care Management Program	8-A	Care Management Responsibilities
1	Monthly	1-B-2	Unduplicated Number of Disenrolled Medical Care Management Members	8-A	Care Management Responsibilities
1	Monthly	1-B-3	Unduplicated Number of Members Enrolled in the Medical Care Management Program and Contacted for Purposes of Care Management	8-A	Care Management Responsibilities
1	Monthly	1-B-4	Number of Successful Care Management Contacts to Members Enrolled in the Medical Care Management Program	8-A	Care Management Responsibilities
1	Quarterly	1-B-5	Identification and Monitoring of Over- and Under-Utilization of Services for Members Enrolled in the Medical Care Management Program	8-A	Care Management Responsibilities
1	Monthly	1-B-6	Care Management Staffing Ratios for Members Enrolled in the Medical Care Management Program	8-A	Care Management Responsibilities
1	Monthly	1-B-7	Medical Home Linkage for Members Enrolled in the Medical Care Management	4-B; 8-A	Choice of a Network Provider; Care Management

			Program		Responsibilities
1	Monthly	1-C-1	Unduplicated Number of Newly Enrolled Members in Behavioral Health Care Management Program	8-A	Care Management Responsibilities
1	Monthly	1-C-2	Unduplicated Number of Disenrolled Behavioral Health Care Management Members	8-A	Care Management Responsibilities
1	Monthly	1-C-3	Unduplicated Number of Members Enrolled in the Behavioral Health Care Management Program and Contacted for the Purposes of Care Management	8-A	Care Management Responsibilities
1	Monthly	1-C-4	Number of Successful Care Management Contacts to Members Enrolled in the Behavioral Health Care Management Program	8-A	Care Management Responsibilities
1	Quarterly	1-C-5	Identification and Monitoring of Over- and Under-Utilization of Services for Members Enrolled in the Behavioral Health Care Management Program	8-A	Care Management Responsibilities

1	Monthly	1-C-6	Care Management Staffing Ratios for Members Enrolled in the Behavioral Health Care Management Program	8-A	Care Management Responsibilities
1	Monthly	1-C-7	Medical Home Linkage for Members Enrolled in the Behavioral Health Care Management Program	4-B; 8-A	Choice of a Network Provider; Care Management Responsibilities
1	Monthly	1-E-1	Unduplicated Number of Newly Enrolled Members in the Care Management Program for Foster Care Members	8-A	Care Management Responsibilities
1	Quarterly	1-E-10	Utilization of Medications Categorized by Antidepressant, Antipsychotic, Attention Deficit Hyperactivity Disorder (ADHD), and Psychotropic	8-A	Care Management Responsibilities
1	Monthly	1-E-2	Unduplicated Number of Disenrolled Foster Care Members in Care Management	8-A	Care Management Responsibilities
1	Monthly	1-E-3	Unduplicated Number of Foster Care Members Enrolled in the Care Management Program and Contacted for Purposes of Care Management	8-A	Care Management Responsibilities

1	Monthly	1-E-4	Number of Successful Care Management Contacts to Foster Care Members Enrolled in the Care Management Program	8-A	Care Management Responsibilities
1	Quarterly	1-E-5	Identification and Monitoring of Over- and Under-Utilization of Services for Foster Care Members Enrolled in the Care Management Program	8-A	Care Management Responsibilities
1	Monthly	1-E-6	Care Management Staffing Ratios for Foster Care Members Enrolled in Care Management Program	8-A	Care Management Responsibilities
1	Monthly	1-E-7	Medical Home Linkage for Foster Care Members Enrolled in the Care Management Program	4-B; 8-A	Choice of a Network Provider; Care Management Responsibilities
1	Quarterly	1-E-8	Screenings and Assessments Completed within Timeframe Identified in Settlement Agreement	8-A	Care Management Responsibilities
1	Quarterly	1-E-9	Utilization of Ongoing Assessments and Examinations	8-A	Care Management Responsibilities
2	Monthly	2-A-1	Member Enrollment Statistics and Trends	4-K	Member Listing Report

2	Monthly	2-A-2	Description of Any Member Enrollment Trends	4-K	Member Listing Report
2	Monthly	2-B-1	Medical Utilization Statistics and Trends (excludes behavioral health)	9-N	Utilization Review
2	Monthly	2-B-10	Rebated Drug Volume	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-B-11	Top 50 Members	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-B-1-1	Behavioral Health Utilization Statistics and Trends	5-E; 9-N	Behavioral Health/Substance Use Disorder; Utilization Review
2	Monthly	2-B-12	Advanced Imaging Services Utilized	5-F; 9-N	Prescription Drugs, Physician-Administered Drugs

					and Implantable Drug System Devices; Utilization Review
2	Monthly	2-B-1-2	Behavioral Health Utilization Statistics and Trends – Injectable Anti-Psychotics	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-B-1-3	Description of Behavioral Health Utilization Trends	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-B-2	Description of Any Utilization Trends (excludes behavioral health)	9-N	Utilization Review
2	Monthly	2-B-3	Pharmaceutical Statistics	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug

					Utilization Data
2	Monthly	2-B-4	Top 100 Drugs by Utilization	5-F; 9-N; 10-S	Prescription Drugs, Physician- Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-B-5	Top 100 Drugs by Amount Paid	5-F; 9-N; 10-S	Prescription Drugs, Physician- Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-B-6	Validation Preferred Drug List Use	5-F	Prescription Drugs, Physician- Administered Drugs and Implantable Drug System Devices
2	Monthly	2-B-7	Pharmacy Prior Authorization Report	5-J	Prior Authorizations

2	Monthly	2-B-8	Physician Administered Drugs and Implantable Drug System Devices	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-B-9	Exception Report Clinical Trials and/or Investigative or Experimental Drugs	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-C-1	Claims Processing Statistics	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
2	Monthly	2-C-1-1	Behavioral Health Claims	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems

2	AdHoc	2-C-1-1-AH	Pended/Suspended Behavioral Health Claims	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
2	Monthly	2-C-1-2	Behavioral Health Claims Denial Reason	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
2	AdHoc	2-C-1-AH	Pended/Suspended Claims (excludes behavioral health)	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
2	Monthly	2-C-2	Physician Administered Drugs (PAD), Number Administered (includes behavioral health)	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-C-2-AH	Physician Administered Drug Claims, Denied Claims – Other	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System

					Devices; Utilization Review; Drug Utilization Data
2	Monthly	2-C-3	Medical Claims Denial Reason (excludes behavioral health)	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
2	Monthly	2-C-4	Claims Processing Statistics – Pharmacy	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
2	Monthly	2-C-5	Pharmacy Claims Denial Reason	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
2	Monthly	2-D-1	Call Center Statistics – All CCO Calls (excludes behavioral health)	6-A; 7-H-1	Member Services Call Center; Provider Services Call Center
2	Monthly	2-D-1-1	Call Center Statistics – All CCO Calls (Behavioral Health Only)	6-A	Member Services Call Center

2	Monthly	2-D-1-2	Call Center Statistics – Member Hotline Calls (Behavioral Health Only)	6-A; 15-E	Member Services Call Center; Liquidated Damages
2	Monthly	2-D-1-3	Member Hotline – Types of Calls (Behavioral Health Only)	6-A	Member Services Call Center
2	Monthly	2-D-1-4	Call Center Statistics – Provider Hotline Calls (Behavioral Health Only)	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
2	Monthly	2-D-1-5	Provider Hotline –Types of Calls (Behavioral Health Only)	7-H-1	Provider Services Call Center
2	Monthly	2-D-1-6	Call Center Statistics – Behavioral Health Clinical Line Calls	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
2	Monthly	2-D-1-7	Member Nurse Line – Types of Behavioral Health Clinical Line Calls (behavioral health only)	6-A	Member Services Call Center
2	Monthly	2-D-2	Call Center Statistics – Member Hotline Calls (excludes behavioral health)	6-A; 15-E	Member Services Call Center; Liquidated Damages
2	Monthly	2-D-3	Member Hotline – Types of Calls (excludes behavioral health)	6-A	Member Services Call Center

2	Monthly	2-D-4	Call Center Statistics – Provider Hotline Calls (excludes behavioral health)	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
2	Monthly	2-D-5	D-5. Provider Hotline –Types of Calls (excludes behavioral health)	7-H-1	Provider Services Call Center
2	Monthly	2-D-6	Call Center Statistics – Member Nurse Line Calls (excludes behavioral health)	6-A; 15-E	Member Services Call Center; Liquidated Damages
2	Monthly	2-D-7	Member Nurse Line – Types of Nurse Line Calls (includes behavioral health)	6-A	Member Services Call Center
2	Monthly	2-E-1	Medical Provider Network (excludes behavioral health)	Section 7	Provider Network
2	Monthly	2-E-1-AH	Terminated Provider Report	7-D	Provider Terminations
2	Monthly	2-E-2	Behavioral Health Provider Network	Section 7	Provider Network
2	AdHoc	2-E-2-AH	Terminated Provider Report	7-D	Provider Terminations
2	Monthly	2-F-1	Overall Prior Authorization Requests Received (includes behavioral health)	5-J	Prior Authorizations
2	AdHoc	2-F-1-AH	Prior Authorization Ad-Hoc Report	5-J	Prior Authorizations

2	Monthly	2-F-2	Prior Authorization Turn Around Time Report	5-J	Prior Authorizations
2	AdHoc	2-F-2-AH	Prior Authorization Turn Around Time Ad-Hoc Report	5-J	Prior Authorizations
2	Monthly	2-F-3	Pharmacy Prior Authorizations	5-J	Prior Authorizations
2	Monthly	2-F-3-AH	Pharmacy Prior Authorization Ad-Hoc	5-J	Prior Authorizations
2	Monthly	2-F-4	Authorized Delivery Report	9-O	Reporting Maternity Admissions for Delivery
2	Monthly	2-G-1	Encounter Data Acceptance Rate	10-R	Member Encounter Data
2	Monthly	2-G-2	Description of Encounter Data Acceptance Rate Trends	10-R	Member Encounter Data
2	Monthly	2-H-1	Medical Member Complaints Summary (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
2	Monthly	2-H-7	Behavioral Health Member Complaint Summary	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
2	Monthly	2-H-8	Behavioral Health Member Complaint Detail	6-K	Member Complaint, Grievance, Appeal and State Fair

					Hearing Process
2	Monthly	2-H-9	Behavioral Health Member Grievance Summary	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
2	Monthly	2-H-10	Behavioral Health Member Grievance Detail	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
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2	Monthly	2-H-3	Medical Member Grievances Summary (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
2	Monthly	2-H-4	Medical Member Grievances Detail (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
2	Monthly	2-I-1	Provider Complaint Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process

2	Monthly	2-I-7	Behavioral Health Provider Complaints Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
2	Monthly	2-I-8	Behavioral Health Provider Complaints Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
2	Monthly	2-I-9	Behavioral Health Provider Grievances Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
2	Monthly	2-I-10	Behavioral Health Provider Grievances Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
2	Monthly	2-I-2	Provider Complaint Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
2	Monthly	2-I-3	Provider Grievances Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative

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2	Monthly	2-I-4	Provider Grievances Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
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2	Annually	2-E-3	Provider Directory Delivery Report	6.E	Member Services
2	Monthly	2-F-5	Resubmission of Authorized Maternity Delivery Report	9.O	Quality Management

2	Monthly	2-K-1	Provider Network - X08 Providers		
2	Quarterly	2-K-2	0359T Behavior Identification Assessments		
2	Monthly	2-K-3	ASD Claims		
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2	Monthly	2-H-11	Behavioral Health Member Appeals Summary	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process

2	Monthly	2-H-12	Behavioral Health Member Appeals Detail	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
2	Monthly	2-I-5	Provider Appeals Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
2	Monthly	2-I-6	Provider Appeals Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
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