AMENDMENT NUMBER TEN
TO THE CONTRACT BETWEEN
THE DIVISION OF MEDICAID
IN THE OFFICE OF THE GOVERNOR
AND
A CARE COORDINATION ORGANIZATION (CCO)

(UnitedHealthcare of Mississippi, Inc.)

THIS AMENDMENT NUMBER TEN modifies, revises, and amends the Contract entered into by and between the **Division of Medicaid in the Office of the Governor**, an administrative agency of the **State of Mississippi** (hereinafter "DOM" or "Division"), and **UnitedHealthcare of Mississippi, Inc.** (hereinafter "CCO" or "Contractor").

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

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

WHEREAS, DOM contracted with the CCO to obtain services for the benefit of certain Medicaid beneficiaries;

WHEREAS, pursuant to Section 17.M.1 and Section 1.B of the Contract, no modification or change to any provision of the Contract shall be made unless it is mutually agreed upon in writing by both parties and is signed by a duly authorized representative of the CCO and DOM as an amendment to the Contract, and such amendments shall be effective upon execution and approval;

WHEREAS, the parties have previously modified the Contract in Amendments #1, #2, #3, #4, #5, #6, #7, #8, and #9; and,

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

I. Section 1. GENREAL PROVISIONS is amended to include the following clauses:

S. APPROVAL

It is understood that if this contract requires approval by the Public Procurement Review Board and/or the Mississippi Department of Finance and Administration Office of Personal

Service Contract Review, and this contract is not approved by the PPRB and/or OPSCR, it is void and no payments shall be made hereunder.

T. 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 Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*.

II. Section 1.A, TERM is amended to read as follows:

The contract period begins July 1, 2017 and shall terminate on June 30, 2022.

III. Section 5.J.2.a, EMERGENCY ADMISSION REVIEWS, is amended to read as follows:

The Contractor shall have the capability and established procedures to receive Emergency Admission Reviews for post-admissions that are not planned or elective and conduct prior authorizations when the Member has not been discharged. The Contractor shall ensure determinations for Emergency Admission Reviews are completed ninety-eight percent (98%) of the time within one (1) business day of receipt.

IV. Section 5.J.2.b, NON-EMERGENCY ADMISSION REVIEWS, is amended to read as follows:

The Contractor shall have the capability and established procedures to receive Non-Emergency Admission Reviews requests and conduct prior authorizations prior to the planned date of admission. The Contractor shall ensure determinations for Non-Emergency Admission Reviews are completed ninety-eight percent (98%) of the time within one (1) business day of receipt.

V. Section 5.J.2.c, WEEKEND AND HOLIDAY ADMISSION REVIEWS, is amended to read as follows:

The Contractor shall have the capability and established procedures to receive Weekend and Holiday Admission Reviews requests and conduct prior authorizations post-admission when the Member has not been discharged. The Contractor shall ensure determinations for Weekend and Holiday Admission Reviews are completed ninety-eight percent (98%) of the time within one (1) business day of receipt.

VI. Section 5.J.2.d, CONTINUED STAY REVIEWS, is amended to read as follows:

The Contractor shall have the capability and established procedures to receive Continued Stay Reviews requests for additional inpatient days of care for admissions previously

certified and conduct prior authorizations on or before the next review point (i.e. the last certified day). The Contractor shall ensure determinations for Continued Stay Reviews are completed ninety-eight percent (98%) of the time within one (1) business day of receipt when Members remain hospitalized and within one (1) business day of receipt when Members have been discharged.

VII. Section 13.A, CAPITATION PAYMENTS, is amended to include:

11. Acceptance of Capitation Rate
Once the Division notifies the Contractor that the capitation rates and risk adjustment developed by the Division and its actuary are final and not subject to further negotiation, the Contractor must accept capitation rates and risk adjustment methodology within ten (10) business days of such rates being presented to the Contractor by the Division. Acceptance of such capitation rates and risk adjustment methodology shall be indicated by execution of an amendment to this Contract incorporating such rates or methodology. Any capitation rates and risk adjustment methodology subsequently disapproved by CMS shall be deemed null and void immediately upon notification by CMS to the Division of the disapproval. The Division shall notify the Contractor of CMS approval or disapproval of any capitation rates or risk adjustment methodology within two (2) business days of receipt of such approval or disapproval. The Division will adjust previously paid funds to reflect the capitation rates and risk adjustment methodology ultimately approved by CMS.

VIII. Section 13.B, MISSISSIPPI HOSPITAL ACCESS PROGRAM, is amended to read as follows:

B. Mississippi Hospital Access Program
The Mississippi Hospital Access Program (MHAP) includes a directed payment provision as defined in 42 C.F.R. § 438.6 for hospitals estimated using the total pool of funds and the expected enrollment for each Rating Period. The Division will annually distribute to the MississippiCAN Contractors the MHAP directed payments in the amount of the annual limit as approved by CMS. The Contractor shall receive monthly Capitation Payments that will include MHAP. Within five (5) business days of receipt of monthly Capitation Payments, the Contractor shall distribute the MHAP funds with no amount withheld for administrative cost. Annual settlement payments, recoupments or capitation rate adjustments will be issued by the Division to ensure the MHAP pool is distributed but not exceeded, due to fluctuations in member enrollment and the distribution of enrollment between Contractors. Within five (5) business days of receipt of any annual settlement payments, the Contractor shall distribute the MHAP funds with no amount withheld for administrative cost. The Division will notify the Contractor fifteen (15) days in advance of a settlement recoupment. The Division will reconcile the total amount paid to Contractor

for MHAP on an annual basis after a period of time for Member Month runout has occurred.

The Contractor shall report to the Division the date and amount of all MHAP distributions, made by the Contractor or any Subcontractor, by hospital and in the Division's required format, by the fifth business day of each month following the date of payment.

The Division will administer any and all programs related to MHAP payments, with the Contractor only acting as a payor, withholding no administrative costs or fees. The Contractor shall participate in stakeholder meetings and otherwise cooperate with the Division in distribution of these payments to maintain hospital funding and/or comply with Federal requirements. The Division reserves the right to modify these payments to comply with state and federal regulations.

IX. Section 13.G, MEDICAL LOSS RATIO, is amended to read as follows:

G. Medical Loss Ratio

The Contractor shall provide quarterly and annual Medical Loss Ratio (MLR) reports as specified by the Division and in accordance with Exhibit C, Medical Loss Ratio (MLR) Calculation Methodology, of this Contract. The Division reserves the right to make such reports available to the public in their entirety. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-seven and one-half percent (87.5%), the Contractor shall refund the Division the difference 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 C of this Contract for MLR calculation methodology and classification of costs.

X. Section 13, FINANCIAL REQUIREMENTS, is amended to include:

13.1.9., LOSS OF PROGRAM AUTHORITY

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work.

If the state paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

J. Mississippi Medicaid Access to Physician Services

The Mississippi Medicaid Access to Physician Services (MAPS) is a directed payment arrangement that is a uniform percentage increase applied to utilization during the payment arrangement period. MAPS has been established by the state for eligible physicians and professional practitioners as defined in the preprint including the payment arrangement and approval, which is pursuant to 42 C.F.R. § 438.6(c). MAPS is eligible to state-owned academic health science centers with a Level 1 trauma center, Level 4 neonatal intensive care nursery, organ transplant program and more than a four hundred physician multispecialty practice group.

MAPS payments are made quarterly during the state fiscal year plus a final reconciliation for the year. When the Contractor receives payment of MAPS, it shall be paid to the provider within five (5) business days of receipt. The Contractor shall distribute the MAPS funds with no amount withheld for administrative cost.

K. Autism Spectrum Disorder

The Autism Spectrum Disorder (ASD) directed payment arrangement is to reimburse providers based on services provided to members in the MississippiCAN program. The payment arrangement targets all Medicaid enrollees of the MississippiCAN program up to age 21 with a diagnosis of ASD. Due to a low number of beneficiaries with an ASD diagnosis receiving ASD services at a low Medicaid rate, the rate adjustments provided in the ASD preprint are intended to improve access to care and to attract additional providers who will provide ASD services to Mississippi CAN members. The fee schedule serves as the payment methodology, which is attached to the preprint. The preprint must be approved by CMS annually and is pursuant to 42 C.F.R. § 438.6(c).

XI. The sixth paragraph of Section 18, CLAIMS PAYMENT, is deleted in its entirety.

XII. EXHIBIT C: MEDICAL LOSS RATIO (MLR) REQUIREMENTS is amended to read as attached hereto.

XIII. All other provisions of the Contract are unchanged and it is further the intent of the parties that any inconsistent provisions not addressed by the above amendments are modified and interpreted to conform with this Amendment Number Ten.

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

Mississippi Division of Medicaid

By: _____
Drew L. Snyder
Executive Director

Date: 5/13/21

UnitedHealthcare of Mississippi, Inc.

By: _____
Jeff Wedin
President & Chief Executive Officer

Date: May 13, 2021

STATE OF MISSISSIPPI
COUNTY OF Madison

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **Drew L. Snyder**, in his official capacity as the duly appointed **Executive Director of the Division of Medicaid in the Office of the Governor**, an administrative agency of the **State of Mississippi**, who acknowledged to me, being first duly authorized by said agency that he signed and delivered the above and foregoing written **Amendment Number Ten** 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 13th day of May, 2021.

NOTARY PUBLIC

Pamela M. Thomas

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 96471 PAMELA M. THOMAS Commission Expires July 8, 2022 MADISON COUNTY

My Commission Expires:

STATE OF Mississippi
COUNTY OF Rankin

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **Jeff Wedin,** in his respective capacity as the **President and Chief Executive Officer of UnitedHealthcare of Mississippi, Inc.,** a corporation authorized to do business in Mississippi, who acknowledged to me, being first duly authorized by said corporation that he signed and delivered the above and foregoing written **Amendment Number Ten** for and on behalf of said corporation and as its official act and deed on the day and year therein mentioned.

GIVEN under my hand and official seal of office on this the 13 day of May, 2021.

NOTARY PUBLIC

Rachel M Clark

My Commission Expires:

May 29, 2023

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 127976 RACHEL M. CLARK Commission Expires May 29, 2023 RANKIN COUNTY

EXHIBIT C: MEDICAL LOSS RATIO (MLR) REQUIREMENTS

The Contractor is required to rebate a portion of the Capitation Payment to the Division in the event the Contractor does not meet the eighty-seven and one-half percent (87.5%) minimum MLR standard. This Exhibit describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention 4) payment of any rebate due to the Division, and 5) liquidated damages that may be assessed against the Contractor for failure to meet requirements.

These requirements are adapted from 42 C.F.R. Part 438.8 Federal Register, including requirements incorporated into the Medicaid and Children's Health Insurance Program Managed Care Final Rule published May 6, 2016 and effective July 5, 2016.

A. Reporting Requirements

1. General Requirements

   For each MLR Reporting Quarter and Year, the Contractor must submit to the Division a report which complies with the requirements that follow concerning Capitation Payments received and expenses related to MississippiCAN Members [42 CFR 438.8(a)] (referred to hereafter as MLR Report). A run-out period of 180 days is required for the final annual MLR report. For the quarterly report, use the state fiscal year-to-date information with a 30-day run-out period.

2. Timing and Form of Report

   The report for each MLR Reporting Year must be submitted to the Division by April 1st of the year following the end of an MLR Reporting Year, in a format and in the manner prescribed by the Division.

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

3. 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. § 438.608(a) (1) through (5), (7), (8) and (b)

d. Non-claims costs

e. Premium revenue

f. Taxes, licensing and regulatory fees

g. Methodologies for allocation of expenditures

h. Any credibility adjustment applied

i. Supporting schedules/documentation for any adjustments made to items a-h.

j. Reconciling supplemental schedule(s) supporting the amounts claimed for all third parties (including related parties) and/or sub-capitated vendors included in amounts reported on the MLR Report for items a-i. Obtained in accordance with the requirements of 42 C.F.R. § 438.8(k)(3)

k. The Calculated MLR

l. Any remittance owed to the State

m. A comparison of the information reported in the MLR Report to the Audited Financial Statement

n. A description of the aggregation method used

o. The number of Member Months

5. Attestation

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

6. Recalculation of MLR

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

B. 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.

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

2. Amounts that must be deducted from incurred claims include:

    a. Overpayment recoveries received from Network Providers;

    b. Prescription drug rebates received and accrued by the Contractor, as well as rebates available and retained by the pharmacy benefit manager

3. Expenditures that must be included in incurred claims include:

    a. The amount of incentive and bonus payments made, or expected to be made, to Network Providers;

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

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

    Fraud Prevention Expenses are defined as expenses incurred prior to the payment of a claim to prevent fraudulent claim payments These expenses are considered routine program integrity activities that the Contractor should be performing and are to be classified as non-claims costs.

    Fraud Reduction Expenses are defined as expenses incurred subsequent to the payment of a claim to specifically identify and detect fraudulent claims for recoupment. (Note: all other post payment claim review activities ensuring proper claim payment performed by the Contractor as part of their program integrity duties are to be considered non-claims cost.)

4. Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

5. Amounts that must be excluded from incurred claims:

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

    b. Amounts paid to the State as remittance under 42 C.F.R. § 438.8(j);

c. Amounts paid to network providers under 42 C.F.R. § 438.6(d);

d. Amounts identified during the analysis of third-party subcontractors as specified in Section J;

e. Spread Pricing amounts paid to a pharmacy benefit manager (PBM); and

f. The amount of reinsurance premiums that exceed the reinsurance recoveries, as these are non-claims costs.

C. 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. § 158.151.

3. Exclusions

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

a. Those that are designed primarily to control or contain costs;

b. The pro rata shares of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;

c. Those which otherwise meet the definitions for quality improvement activities, but which were paid for with grant money or other funding separate from premium revenue:

d. Those activities that can be billed or allocated by a Provider for care delivery and which are, therefore, reimbursed as clinical services;

e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended;

f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

g. All retrospective and concurrent utilization review;

h. Fraud prevention activities;

i. The cost of developing and executing Provider contracts and fees associated with establishing or managing a Provider Network, including fees paid to a vendor for the same reason;

j. Provider credentialing;

k. Marketing expenses;

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

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

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

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

p. Any function or activity not expressly included in paragraph one (1) or two (2) of this section, unless otherwise approved by and within the discretion of the Division, upon adequate showing by the Contractor that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

Note: The Contractor must also possess documentation for the source expense, methodology for determining how the expense meets the above definition of an expense that improves healthcare quality improvement, the allocation methodology and statistics utilized for any allocation.

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 a Contractor or PIHP.

    b. Administration or validation of consumer or provider surveys of quality of care.

    c. Calculation of performance measures in addition to those reported by a Contractor or PIHP and validated by an EQRO.

    d. Conduct of performance improvement projects in addition to those conducted by a Contractor or PIHP and validated by an EQRO.

    e. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

4. Technical assistance. The EQRO may, at the State's direction, provide technical guidance to groups of Contractors or PIHPs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

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

1. General Requirements

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

a. Making incentive payments to health care Providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services; as defined in 45 C.F.R. § 158.140;

b. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care Providers, including those not eligible for Medicare and Medicaid incentive payments;

c. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

d. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law;

e. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

f. Advancing the ability of Members, Providers, the Contractor or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic health records accessible by Members and appropriate Providers to monitor and

document an individual patient's medical history and to support Care Management;

g. Reformatting, transmitting or reporting data to national or international government-based health organizations, as may be required by the Division, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and,

h. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

F. 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 L).

2. Non-Claims Costs Other

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

a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity;

b. Loss adjustment expenses not classified as a cost containment expense;

c. Workforce salaries and benefits;

d. General and administrative expenses; and

e. Community benefit expenditures.

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

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

transactions are between related parties. Refer to Medicare Final Rule 42 C.F.R. § 422.516(b).

3. Expenses Not Allowable as Non-Claims Costs

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

a. charitable contributions made by Contractor;

b. any penalties or fines assessed against Contractor;

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

d. any lobbying and political activities, events, or contributions;

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

f. alcoholic beverages;

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

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

i. Bad Debts of the Contractor;

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

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

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

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

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

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

p. Investment Management Costs;

q. Proposal Costs;

r. Rebates and Profit Sharing (Profit sharing or rebate arrangements between the Contractor and a Subcontractor resulting in fees or assessments which are not tied to specifically identified services that directly benefit the Contract are unallowable unless specifically allowed by Contract. This fee effectively becomes a form of profit payment or rebate);

s. Royalty Agreements (associated fees, payments, expenses, and premiums);

t. Losses in excess of the remaining depreciable basis for the disposition of depreciable property;

u. Costs in excess of what a reasonable or prudent buyer would pay for goods or services.

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

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

G. <u>Mississippi Hospital Access Program (MHAP)/ Mississippi Access to Physician Services (MAPS)</u>

The MLR Report will include all MHAP and MAPS payments received by the Contractor reported as Capitation Revenue on the MLR Report for dates of service within the Rating Period, including any adjustments. The same amounts reported in the denominator as capitation revenues for MHAP and MAPS shall be reported in the numerator as medical expenses.

H. 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.

I. 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.

J. Third Party Subcontractors

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

1. Sub-Capitated Vendors

   The Contractor must report to the Division the total expenses incurred by the third party vendor for clinical services provided to members, activities that Improve Health Care Quality, activities related to external Quality review, expenditures related to Health Information Technology and Meaningful Use Requirements, and non-claims cost incurred by the sub-capitated vendors. The sub-capitated payments should be adjusted to reflect the aforementioned expenses to the third party. When the sub- capitation payments to the third party vendor exceed third party vendor's actual costs, the excess (profit margin), should be considered administrative non-claim costs from non-related vendors. When these transactions occur between related parties, there must be justification that these higher costs are consistent with prudent management and fiscal soundness policies to be included as allowable administrative non-claim costs. Refer to Medicare Final Rule 42 C.F.R. § 422.516(b).

2. Management Fee Arrangement

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

K. Maintenance of Records

The Contractor must maintain and retain, and require Subcontractors to retain, as applicable, for a period of no less than ten (10) years, in accordance with 42 C.F.R. § 438.3(u), and make available to the Division upon request the data used to allocate expenses reported, together

with all supporting information required to determine that the methods identified and reported as required under this Exhibit C were accurately implemented in preparing the MLR Report.

L. Formula for Calculating Medical Loss Ratio

1. Medical Loss Ratio

   a. 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.

2. Rebating Capitation Payments if the eighty-seven and one-half percent (87.5%) 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-seven and one-half percent (87.5%) 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-seven and one-half percent (87.5%) and the Contractor's actual MLR.

c. Timing of Rebate

The Contractor must provide any rebate owing to the Division no later than the tenth (10th) business day of May following the year after the MLR Reporting Year.

d. Late Payment Interest

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