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

(UnitedHealthcare of Mississippi, Inc. – Children's Health Insurance Program)

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 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 §§ 438.3(b) and 457.1201 and is engaged in the business of providing comprehensive services as outlined in 42 CFR § 457.10. 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 a separate child health program in accordance with Section 2102(a)(1) of the Social Security Act and 42 C.F.R § 457.70 and the CCO has provided to DOM continuing proof of the CCO'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 the Contract, upon which DOM relies in entering into this Amendment Number Ten;

WHEREAS, pursuant to 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

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

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:

1. Section 2.A, DEFINITIONS is hereby amended to add the following definition:

   95. **Certified Community Behavioral Health Clinic (CCBHC):** a specially designated clinic that provides a comprehensive range of mental health and substance use services in accordance with federal criteria and with the requirements of the Protecting Access to Medicare Act of 2014 (PAMA). Certified Community Behavioral Health Clinic (CCBHC) as defined in Section 223 PAMA and Section 3814 CARES Act.

2. Section 2.B., ACRONYMS is hereby amended to add the following:

   53. CCBHC – Certified Community Behavioral Health Clinic

3. Section 7.D.1, PROVIDER NETWORK – Provider Terminations – Terminations by the Contractor, is hereby amended to only revise the language of the second paragraph under subsection 1 as follows:

   1. Termination by the Contractor

      For PCPs and hospital terminations and at the discretion of the Division, the Contractor must submit a Provider termination work plan and supporting documentation within ten (10) business days of the Contractor's notification to the Division of the termination and must provide weekly updates to this information. 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, as applicable, may include, but is not limited to the submission of:

      a. Provider Impact and Analysis;
      b. Updated Provider Network and/or Provider Affiliation File;
      c. Provider Notification of the Termination;
      d. Member Impact and Analysis;
      e. Member Notification of the Termination;
      f. Member Transition and Continuity of Care;
      g. Systems Changes;
      h. Provider Directory Updates for the Division's Agent (include date when all updates will appear on Provider files);
      i. Contractor Online Directory Updates;

j. Submission of Required Documents to the Division (Member notices for prior approval);
k. Submission of Final Member Notices to the Division;
l. Communication with the public related to the termination; and
m. Termination Retraction Plan, if necessary.

All other language not modified as stated herein for Section 7.D.1 shall remain unchanged and in full force and effect.

4. Section 7.D.2, PROVIDER NETWORK – Provider Terminations – Terminations by the Provider, is hereby amended to only revise the language of the second paragraph under subsection 2 as follows:

2. Termination by the Provider

At the discretion of the Division, Contractor must submit a Provider termination work plan that may include, as applicable, 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. All other language not modified as stated herein for Section 7.D.2 shall remain unchanged and in full force and effect.

5. Section 7.J.1., PROVIDER NETWORK – Reimbursement; Claims Payment, Denial, and Appeals, is hereby amended to remove and delete the following Amendment 6 language:

The Contractor shall make payments under the Contract that are considered state directed payments (SDPs) with a minimum fee schedule tied to State Plan approved rates in accordance with 42 CFR § 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii). These minimum fee schedule payments are required in accordance with Miss. Code Ann. § 43-13-117(H).

All other language not modified as stated herein for Section 7.J.1 shall remain unchanged and in full force and effect.

6. Section 10.P., REPORTING REQUIREMENTS – Health Information System, is hereby amended to add the following:

The Contractor shall work with the IT/Data Systems Work Group of the Mississippi Certified Community Behavioral Health Clinic (CCBHC) Planning Grant Steering Committee to define a mutual statement of work and schedule to

implement software and hardware routing solutions required for the successful implementation of CCBHCs.

7. Section 10.S., REPORTING REQUIREMENTS - Claims Processing and Information Retrieval Systems, is hereby amended to add the following:

In preparation for the planned CCBHC program to be initiated at a future date upon authorization by the Division, the Contractor shall, as requested by the Division, provide resources and initiate participation in the IT/Data Systems Workgroup of the Mississippi Certified Community Behavioral Health Clinic (CCBHC) Planning Grant Steering Committee to ensure their claims systems are prepared to process claims with the new CCBHC provider type.
Contractor shall provide appropriate Subject Matter Experts (SMEs) experienced with CCBHC operations and systems as requested by the Division to participate in regularly scheduled CCBHC meetings as coordinated by the Division. Contractor SMEs shall provide input at the scheduled CCBHC meetings relative to planning, implementation, and operation of the CCBHC program.

In accordance with the requirements of PAMA, the Division will establish a prospective payment system (PPS) rate for the payment of CCBHC services. This PPS rate will cover all services provided to a beneficiary on a daily basis for all of the services included in the scope of services of the CCBHC. The Contractor will be required to initiate and prepare their internal payment systems to incorporate this PPS rate methodology.

8. Section 12.A.9., FINANCIAL REQUIREMENTS – Capitation Rate, is hereby amended to add the following:

9. <u>Capitation Rate</u>

The established Coordinated Care Organization capitation rate per member per month (PMPM) for Children's Health Insurance Program (CHIP) for the period from July 1, 2023 through June 30, 2024 is $260.82. (See Exhibit 1 to this Amendment 10).

9. Section 12.A.10., FINANCIAL REQUIREMENTS – Risk Corridor, is hereby amended to add the following:

10. Risk Corridor- State Fiscal Year (SFY) 2024

(a) Program-Wide Risk Corridor – State Fiscal Year (SFY) 2024

Subject to CMS approval, the Division will implement a symmetrical program-wide risk corridor for the timeframe of July 1, 2023 through June 30, 2024 ("SFY 2024") to address the uncertainty of medical costs related to the federally required COVID-19 Public Health Emergency (PHE) unwinding during SFY 2024. The program-wide risk corridor was developed in accordance with generally accepted actuarial principles and practices.

The Contractor capitation rate reflects a target medical loss ratio (MLR), which measures the projected medical service costs as a percentage of the total capitation rate paid to the Contractor. The program-wide risk corridor would limit Contractor gains and losses if the actual MLR is different than the target MLR.

The following table summarizes the share of gains and losses relative to the target MLR for each party.

Mississippi Division of Medicaid SFY 2024 Program-Wide Risk Corridor Parameters		
MLR Claims Corridor	**Contractor Share of Gain/Loss in Corridor**	**Division Share of Gain/Loss in Corridor**
Less than Target MLR -2.0%	0%	100%
Target MLR -2.0% to Target MLR +2.0%	100%	0%
Greater than Target MLR +2.0%	0%	100%

For purposes of the SFY 2024 Program-Wide Risk Corridor, a different definition of the MLR will be used than the Federal MLR definition. The last column of **Exhibit 3** from the September 27, 2023 certification letter illustrates the calculation of the target MLR for the Contractor and is hereby attached and incorporated as Exhibit 1 to this Amendment10.

The Program-Wide Risk Corridor will be implemented using the following provisions:

1) Actual and Target MLRs will be calculated separately for each CCO based on their actual enrollment mix.

2) The numerator of each CCO's actual MLR will include state plan covered services incurred during the period of SFY 2024 with payments made to providers as defined in Exhibit D of the CCO Contract, including fee for-service payments, subcapitation payments, and settlement payments. Non-covered services will be removed from the numerator.

(3) The High-Cost Pharmacy Risk Corridor will be calculated independent of the Program-Wide Risk Corridor. Costs and premiums associated with the High-Cost Pharmacy Risk Corridor will not be accounted for or included in the calculation of the Program-Wide Risk Corridor.

4) Adjustments to revenue and claims resulting from the MLR audit will be incorporated into the calculation of each CCO's actual MLR.

5) The 85% minimum MLR provision in Section 12.E of the Contract will apply after the risk corridor settlement calculation.

The initial program-wide risk corridor calculation and settlement will occur using the SFY 2024 values included in the annual MLR report submitted from the Contractor to the Division with six (6) months of runout. Any payment or recoupment between the Division and Contractor based on this initial settlement will occur in the month of May after the close of the state fiscal year. A final calculation of payments or recoupments as a result of the program-wide risk corridor will occur once the MLR audit has been completed, typically 12 to 18 months after the close of the state fiscal year.

(b) Risk Corridor for Pharmacy High-Cost Drugs - State Fiscal Year (SFY) 2024

Some Medicaid members have conditions requiring very expensive drug treatments. These members are infrequent and not evenly distributed among the CCOs. To help mitigate the CCO's risk, the state is introducing a pharmacy high-cost drug risk corridor for SFY 2024, subject to CMS approval. The pharmacy high-cost drug risk corridor is applicable to total drug spend of $500,000 or more per year at a member level. The capitation rates include a PMPM estimate of the costs that will be covered in the pharmacy high-cost drug risk corridor specific to each population. The actual costs from the CCOs will be compared to these estimated costs for the final settlement calculation.

The pharmacy high-cost drug risk corridor outlined below has been developed in accordance with generally accepted actuarial principles and practices. The table below summarizes the share of gains and losses relative to the estimated high-cost pharmacy costs for each party.

Mississippi Division of Medicaid Risk Corridor Parameters for Pharmacy High-Cost Drugs SFY 2024		
Contractor Gain/Loss	**Contractor Share of Gain/Loss in Corridor**	**Division Share of Gain/Loss in Corridor**
Less than -6.0%	0%	100%
-6.0% to -3.0%	50%	50%
-3.0% to +3.0%	100%	0%
+3.0% to +6.0%	50%	50%
Greater than +6.0%	0%	100%

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

(1) Estimated high-cost pharmacy costs will be calculated separately for each Rate Cell based on the expected mix of high-cost products.

(2) Each Rate Cell's actual high-cost pharmacy costs will include payments made for the following:

(a) All pharmacy claims with an NDC code billed through a retail or specialty pharmacy, regardless of where these claims are administered.

(b) All drugs billed as medical claims with a HCPCS code that starts with the letter "J"

(c) Inpatient stays for select gene therapies and other select products. The estimated pharmacy costs included in the high-cost risk corridor include the following; however, DOM will monitor and revise the list of approved products if additional products are covered by DOM for use during SFY 2024.

i) lovotibeglogene autotemcel (lovo-cel)
ii) exagamglogene autotemcel (exa-cel)
iii) Zynteglo

(d) Applicable script limits will be applied and the costs for those services will not be counted toward total member spend during that time period.

(3) The timing of the pharmacy high-cost drug risk corridor settlements will occur during the initial and final settlements for the program-wide risk corridor. The pharmacy high-cost risk corridor will be calculated independently of the larger program-wide risk corridor. Costs and premiums associated with the High-Cost Pharmacy Risk Corridor will not be

accounted for or included in the calculation of the Program-Wide Risk Corridor.

(a) The initial settlement will occur after the contract year is closed, using six months of runout. Any payment or recoupment between the Division and Contractor based on this initial settlement will occur in the month of May after the close of the state fiscal year.

(b) The final settlement will occur once the MLR audit has been completed. MLR audits are usually completed 12 to 18 months after the close of the SFY.

(4) The 85% minimum MLR provision (Federal MLR definition) in the CCO contract will apply after the risk corridor settlement calculation.

10. EXHIBIT D: MEDICAL LOSS RATIO (MLR) REQUIREMENTS is hereby amended and replaced with "EXHIBIT D: MEDICAL LOSS RATIO (MLR) REQUIREMENTS" as attached and incorporated herein by reference to this Amendment 10.

All other terms, conditions, and provisions of the Contract and any subsequent amendments, other than those modified herein, remain in full force and effect for the duration of the Contract.

[remainder of this page left intentionally blank]

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

Division of Medicaid:

By: _____
Drew L. Snyder
Executive Director

Date: 12/11/23

UnitedHealthcare of Mississippi, Inc.

By: _____
J. Michael Parnell
Chief Executive Officer

Date: 18 Oct 2023

STATE OF MISSISSIPPI
COUNTY OF Hinds

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **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 11th day of December, A.D., 2023.

NOTARY PUBLIC

My Commission Expires:

Sept 23, 2024

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 64864 SHELBY J. BERRYMAN Commission Expires Sept. 23, 2024 MADISON COUNTY

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, **J. Michael Parnell,** in his respective capacity as the **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 18th day of October, A.D., 2023.

NOTARY PUBLIC

Shalaundrea White

My Commission Expires:

1/27/25

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 279871 SHALAUNDREA WHITE Commission Expires Jan. 27, 2025 HINDS COUNTY

Milliman

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September 27, 2023

Jennifer Wentworth
Special Projects Admin, Accounting
Mississippi Office of the Governor, Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201
Sent via email: jennifer.wentworth@medicaid.ms.gov

Re: Report21 State Fiscal Year 2024 CHIP Preliminary Rate Calculation and Certification

Dear Jennifer:

The Mississippi Division of Medicaid (DOM) has retained Milliman to develop the state fiscal year SFY 2024 capitation rate for the Children's Health Insurance Program (CHIP) population, effective July 1, 2023 to June 30, 2024.

This report documents the preliminary capitation rate for CHIP. Overall, the preliminary SFY 2024 capitation rate is 4.3% higher than the SFY 2023 capitation rate issued on April 20, 2022.

This report updates our preliminary capitation rate.[1]; the following changes were made in this report relative to the prior certification:

- Insulin price adjustments related to the removal of the average manufacturer's price (AMP) cap effective January 1, 2024
- Extension of postpartum coverage from 60 days to 12 months
- Estimated PMPM costs for high-cost pharmacy and other applicable costs that will be included in a high-cost pharmacy risk corridor for SFY 2024
- Removal of the prior Zolgensma carve-out in conjunction with introducing the high-cost pharmacy risk corridor in SFY 2024
- Inclusion of newly covered costs for gene-therapies for the following conditions:
  - Beta-Thalassemia
  - Duchene Muscular Dystrophy
  - Hemophilia A
  - Hemophilia B
  - Sickle Cell Disease

Table 1 summarizes the overall impact on the capitation rate resulting from the changes, noted above. Each of these changes are described in more detail within the capitation report.

[1] "Report13 – SFY 2024 Preliminary CHIP Rate Calculation and Certification.pdf" dated May 2, 2023.

Table 1
SFY 2024 CHIP Capitation Rate Development
Summary of SFY 2024 Rate Change Components

Assumption Change	Change from May 2, 2023 Preliminary Rate
Postpartum Coverage Extension	1.006
Gene Therapy Coverage	1.027
Insulin Price Reduction	0.998
Total SFY 2024 Rate Change	**1.031**

As of the time of this report, the impact on the capitation rate due to COVID-19 is uncertain for SFY 2024. As such, a risk corridor will be used in SFY 2024. The risk corridor is described in more detail in Section II. In addition, explicit adjustments for COVID-19 are made in the rate development for the following:

- **COVID-19 / Influenza / RSV Adjustment:** We developed an adjustment for the estimated difference in costs included in the CY 2021 base period data and projected SFY 2024 costs for testing, vaccination, and treatment for influenza, respiratory syncytial virus (RSV), and COVID-19. This adjustment reflects an expected decrease in COVID-19 costs and an expected increase in influenza and RSV costs from CY 2021 to SFY 2024.

We will continue to monitor the development of this pandemic and adjust assumptions in the SFY 2024 capitation rate, if appropriate.

❖ ❖ ❖ ❖ ❖

Please call either of us at 262 784 2250 if you have questions. We look forward to discussing this report with you and the CCOs.

Sincerely,

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

Katarina N. Lorenz, FSA, MAAA
Consulting Actuary

JAB/KNL/zk

Attachments

MILLIMAN REPORT

State of Mississippi Division of Medicaid

State Fiscal Year 2024 CHIP Preliminary Rate Calculation and Certification

September 27, 2023

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

Katarina N. Lorenz, FSA, MAAA
Consulting Actuary

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Milliman


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I. SUMMARY AND DISCUSSION OF RESULTS

The Mississippi Division of Medicaid (DOM) retained Milliman to calculate and document the capitation rate for the Children's Health Insurance Program (CHIP) population effective for state fiscal year (SFY) 2024. This report documents the development of the preliminary capitation rate for the CHIP population. This report is structured as follows:

- Section I includes a high-level overview of the change in the capitation rate relative to the SFY 2023 capitation rate.
- Section II describes the methodology used to develop the SFY 2024 CHIP capitation rate.
- Appendix A contains additional information on the base period data sources and processing.
- Appendix B contains an Actuarial Certification for the CHIP rate cell.
- Appendix C documents our reliance on DOM for data and other assumptions in the development of the capitation rate.

COVID-19 CONSIDERATIONS IN SFY 2024 RATE DEVELOPMENT

As of the time of this report, the impact on the SFY 2024 capitation rate due to COVID-19 is difficult to predict. As such, a risk corridor will be in effect in SFY 2024 to reflect the uncertainty in the capitation rate due to COVID-19. The risk corridor is described in more detail in Section II.

In addition, explicit adjustments for COVID-19 are made in the rate development for the following, as described in Section II:

- Seasonal virus adjustment.

The SFY 2024 capitation rate does not include any explicit adjustments for the following:

- Acuity adjustment - we looked at CY 2021 base period data separately for members still enrolled in CHIP as of June 2022 compared to all members. Although we do see an increase in claims PMPM throughout CY 2021 our analysis would not indicate this is a result of the eligibility redeterminations that occurred during CY 2021. Therefore, no acuity adjustment was applied as part of SFY 2024 capitation rate setting.

CAPITATION RATE CHANGE SUMMARY

The per member per month (PMPM) preliminary capitation rate for SFY 2024 is $260.82. As documented in Section II of this report, one statewide rate was selected for SFY 2024 after a review of historical experience by region.

The SFY 2024 CHIP capitation rate is 4.3% higher than the SFY 2023 capitation rate. Table 1 shows a summary of the main drivers of the rate change that make up this change to the capitation rate.

Table 1 Mississippi Division of Medicaid Summary of SFY 2024 Rate Change by Component	
SFY 2023 Capitation Rate	**$250.02**
Base Period Data Update	0.921
Restate CY 2021 to SFY 2023 Utilization Trends	1.051
Restate CY 2021 to CY 2022 PDL Adjustment	1.001
Updates Relative to SFY 2023 Assumptions	**0.969**
Seasonal Virus Adjustment	1.002
Postpartum Coverage Extension	1.006
SFY 2023 to SFY 2024 Trends	1.040
CY 2022 to CY 2023 PDL Adjustment	1.000
Insulin Price Reduction	0.998
Gene Therapy Drug Coverage Expansion	1.028
Gene Therapy Drug Coverage Savings	0.999
Update Admin	1.003
Preliminary SFY 2024 Rate Change	**1.043**

- The development of the SFY 2024 capitation rate is a ground-up approach where the base data and each assumption is evaluated separate from the SFY 2023 capitation rate. However, for the purposes of explaining the rate change from SFY 2023 to SFY 2024, we isolate the impact of rebasing the data and assumptions that we updated relative to the data or assumptions used to develop the SFY 2023 values. Overall, this rebasing decreased the projection of SFY 2023 costs by 3.1% from costs projected in the SFY 2023 capitation rate. This 3.1% decrease contains the following sub-components:
  - CY 2019 claims data was used as the base period for SFY 2023 rate setting, whereas CY 2021 data was used for the SFY 2024 rate. This data update, as shown in the "Base Period Data Update" row above, resulted in a 7.9% decrease.
  - Utilization trend assumptions from CY 2021 to SFY 2023 were restated based upon more recent experience with a resulting increase on the CHIP capitation rate of 5.1%.
  - Milliman restated the impact of PDL changes effective January 1, 2022. This resulted in a rate increase of 0.1% to the capitation rate.
- The seasonal virus adjustment increased the capitation rate by 0.2%. This increase shows the impact of the expected seasonal virus load in SFY 2024 compared to CY 2021 and was based on historical costs observed in CY 2018 and CY 2019.
- Per SB 2212, postpartum coverage extended from 60 days to 12 months for SFY 2024. Previously, pregnant CHIP members were transitioned out of the CHIP program once they were identified as pregnant. In SFY 2024, pregnant CHIP members will not be transitioned to the MississippiCAN program and will instead remain in the CHIP program during their pregnancy and through 12 months of postpartum coverage. We adjusted the CHIP rate cell for the costs associated with pregnant members and the increased postpartum coverage. This adjustment increased the capitation rate by approximately 0.6%.
- Claim costs were increased approximately 4.0% for anticipated utilization and unit charge increases from SFY 2023 to SFY 2024.
- Preferred drug list (PDL) updates effective January 1, 2023 are estimated to have a minimal impact resulting in a negligible change to the capitation rate.
- Insulin manufacturer cost adjustments, related to the removal of the average manufacturer's price (AMP) cap effective January 1, 2024, reduced the capitation rate by 0.2%.
- A high-cost gene therapy for the treatment of Hemophilia B is currently available and authorized for use during SFY 2024. Anticipated medical and pharmacy costs associated with this treatment increased the rate by 2.8%. Anticipated medical savings from this therapy reduced the rate by 0.1%.

- Changes to administrative expenses on a PMPM basis result in an increase to the rate of approximately 0.3%, based upon CCO reported administrative expenses for CY 2021 trended to SFY 2024. A positive rate change in Table 1 indicates that the administrative costs increased as a percentage of the overall rate (i.e., administrative costs trended at a higher percentage than the overall rate.) The overall PMPM for administrative expenses increased 3.0% from the SFY 2023 allowance, comprised of a fixed administrative expense increase from $7.40 PMPM in the SFY 2023 rate to $7.63 PMPM in the SFY 2024 rate, and variable administrative expense increase from 6.91% in the SFY 2023 rate to 6.83% in the SFY 2024 rate.

DATA RELIANCE AND IMPORTANT CAVEATS

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the SFY 2024 CHIP capitation rate. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We used CCO encounter data and CCO financial reporting from January 2021 to August 2022 with runout through August 2022, FFS cost and eligibility data from January 2021 to December 2021, historical and projected reimbursement information, TPL recoveries, fee schedules, pharmacy and dispensing fee pricing, and other information from DOM, CHIP CCOs, Myers and Stauffer, Change Healthcare, and CMS to calculate the preliminary CHIP capitation rate shown in this report. If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete. Please see Appendix C for a full list of the data relied upon to develop the SFY 2024 CHIP capitation rate.

Differences between the capitation rate and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Our report is intended for the internal use of DOM to review the preliminary CHIP capitation rate for SFY 2024. The report and the models used to develop the values in this report may not be appropriate for other purposes. We anticipate the report will be shared with contracted CCOs, CMS and other interested parties. Milliman does not intend to service, and assumes no duty or liability to, other parties who receive this work. It should only be distributed and reviewed in its entirety. This capitation rate may not be appropriate for all CCOs. Any CCO considering participating in CHIP should consider their unique circumstances before deciding to contract under this rate.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

The authors of this report are actuaries employed by Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

II. DEVELOPMENT OF CAPITATION RATE

This section of the report describes the development of the preliminary SFY 2024 CHIP capitation rate.

METHODOLOGY OVERVIEW

The methodology used to calculate the capitation rate can be outlined in the following steps:

1. Summarize financial reporting and encounter data for CY 2021 CHIP enrollees.
2. Trend CY 2021 adjusted experience to SFY 2024.
3. Apply adjustments for program changes.
4. Provide an allowance for non-service expenses.
5. Calculate risk corridor settlements.

Each of the above steps is described in detail below.

Step 1: Summarize Financial Reporting and Encounter Data for CY 2021 CHIP Enrollees

MEMBERSHIP

Member months by region in CY 2021 were summarized from the detailed CHIP eligibility data. These enrollment counts were validated against enrollment information provided by the CCOs. In total, the enrollment in the eligibility files is within 0.04% of enrollment as reported by the CCOs.

Row (a) of Exhibit 1 includes the CY 2021 member months included in base data development.

CLAIM DATA

The encounter data expenditures for both CCOs are combined to summarize CY 2021 claim experience for CHIP enrollees with runout through April 2022. Row (b) of Exhibit 1 includes the CY 2021 total claim costs from the encounter data. Row (c) converts the total costs to a PMPM basis.

All experience used to develop the base period data for the SFY 2024 capitation rate is on a net basis, excluding any member cost sharing, which varies by the income eligibility of the enrolled child's family.

- No copayments are charged to enrolled children in families with an annual income up to 150% FPL
- Enrolled children in families with an annual income above 150% of the FPL are charged the following copayments:
  - Outpatient Health Care Professional Visit, $5.00
  - Emergency Room Visit, $15.00
- Annual out-of-pocket maximums for the following are in place:
  - Families with annual income from 151% to 175% FPL shall pay no more than $800
  - Families with annual income above 175% FPL shall pay no more than $950

No cost sharing is applied to preventive services, including immunizations, well childcare, routine preventive and diagnostic dental services, routine dental fillings, routine eye examinations, eyeglasses, or hearing aids. There is also no cost sharing for American Indian or Alaska Native children.

Effective November 1, 2019, no cost sharing is charged on outpatient mental health and substance use disorder (SUD) visits for all income eligibility levels.

Exhibit 8 contains the databook summarizing the total paid amounts and paid PMPMs in the encounter data for CY 2021.

Data Collection and Validation

DOM and Milliman go through extensive data validation processes to review CCO submitted encounter data. DOM regularly monitors encounter claims compared to cash disbursement journals (CDJs) to ensure the timeliness and completeness of submitted encounters and works with Myers and Stauffer to identify the correct original or final claim to keep in each claim string. Milliman relied on this claim status identification process to remove duplicates and identify denied claims that are anticipated to be resubmitted and accepted, as described in Appendix A.

As part of rate development, Milliman requests financial reporting data from each CCO. This financial reporting data is reconciled to each CCO's CY 2021 audited NAIC financial statement. After several rounds of questions to clarify, adjust, and confirm understanding of the reported financial information, Milliman compared the encounter data to the financial reporting data, together for paid claims and subcapitated claims. This comparison excludes estimates for incurred but not reported (IBNR) claims and adjusts for expanded benefits, pharmacy rebates, and any other claims that were identified as missing from the processed encounter data. The following items are noted:

- Overall, the paid amounts in the encounters reconcile closely to the paid amounts shown in the CCO financial reporting for the CHIP population. Table 2 shows that encounter data is within 0.28% of financial data.
- At a category of service level, there is a greater variance between encounter data and financial reporting, particularly for non-pharmacy categories of service.

Table 2
Mississippi Division of Medicaid
SFY 2024 CHIP Capitation Rate Development
Comparison of Financial and Encounter Data

Difference of Encounters and Financials (% of Encounters)	
IP / OP / Phys / Dental / Other Services	0.35%
Drug Services	0.03%
All Services	0.28%

Given how closely the encounter data reconciles to the financial data submitted by the CCOs, we are not making a financial to encounter adjustment for CY 2021. As an additional source of verification for the encounter data we reviewed the CDJ summaries provided by DOM and were able to validate that the encounter data ties very closely (within 0.6%) to the amounts reported by the CCOs in the CDJ summary reports for similar time periods. Since the CDJ summary reports are on a paid basis (rather than an incurred basis) they do not line up exactly with the time periods we use for rate setting, therefore, we reviewed reports from Q4 2020 through Q1 2022.

The financial reporting expenditures for all CCOs were combined to perform the encounter validation outlined above, as well as to develop the following adjustments to apply to the encounter data:

- Removal of services offered by CCOs that are not covered by the CHIP program
- Removal of pharmacy rebates collected by CCOs
- Removal of costs that would be paid or recouped by third parties
- Addition of IBNR expenses not yet included in encounters
- Addition of claims paid by the CCOs that are not yet reflected in the encounter system

Non-Covered Services

The value of expanded services offered to plan members that were not CHIP covered services during the base data period are excluded from the base data. In CY 2021, these services are non-emergency transportation services offered by one CCO. The costs of expanded services were excluded from paid claims in CCO financial reporting. These services are equivalent to approximately 0.01% of total reported CHIP CY 2021 service costs. Corresponding amounts were removed from the encounter data, as reported by the impacted CCO.

This adjustment is shown in Exhibit 1 in row (d).

Third Party Liability Recoveries

The CCOs provided Milliman with a summary of recoveries for TPL payments related to claims incurred from CY 2021. Using CY 2018 and CY 2019 data, Milliman calculated the portion of total CY 2018 and CY 2019 TPL recoveries recovered after the end of each year. We used this information to estimate the recoveries for claims incurred in CY 2021 not yet reflected in the CY 2021 base data. DOM assumes these outstanding TPL recoveries will offset CY 2021 CCO final paid totals.

We removed the TPL amounts as a percentage of total paid claims across all categories of service from the CY 2021 base data. These TPL recoveries amounted to a 0.07% reduction to CY 2021 base data.

This adjustment is shown in Exhibit 1 in row (e).

Pharmacy Rebate Adjustment

An adjustment was made to pharmacy claims to reflect the average rebate collected by the CCOs in CY 2021 and not reflected in the paid pharmacy data. Rebate costs were summarized from the financial reporting and removed from the paid pharmacy claims. Rebates totaled approximately 7.0% of adjusted pharmacy costs.

This adjustment is shown in Exhibit 1 in row (f).

IBNR Adjustment

The adjustment for IBNR claims as of April 30, 2022, uses the best estimate IBNR claims provided by each of the CCOs in their financial reporting. We performed the following high-level reasonability checks to validate these estimates:

- Data, including IBNR estimates, was reported on a quarterly basis by each CCO. We reviewed the reported IBNR by quarter to determine that there was a reasonable pattern throughout the year (i.e., IBNR amounts held for Q1 2021 were significantly lower than Q4 2021).
- IBNR estimates among the CCOs were reviewed to validate that they were approximately the same as a percentage of total claims, where appropriate.
- IBNR estimates by category of service are approximately the same as a percentage of total claims as IBNR adjustments applied to the CHIP data in prior years after accounting for differences in runout period between years.

Overall, the base data increases by 0.2% on a PMPM basis for IBNR claims.

The IBNR adjustment is shown in Exhibit 1 in row (g).

Missing Data Adjustment

A separate adjustment was made to account for payments made by the CCOs that are not yet submitted to the encounter system or cannot be reasonably applied to a specific claim (e.g., provider bonuses or settlements). These claim amounts are not included in the detailed encounter data after the processing outlined in Appendix A.

Each CCO provided separate financial reporting to support and validate the amounts reported for claims not appearing in encounters. The detailed financial reporting provided by the CCOs included splits by region and rate cell, which were used to allocate missing data on Exhibit 1.

Overall, the base data is increased 0.5% on a PMPM basis for missing data. The aggregate adjustment for all missing data described above is shown in Exhibit 1 in row (h).

FINAL PMPM BASE PERIOD COSTS

Total CY 2021 base period PMPM costs are shown in Exhibit 1 row (i).

Step 2: Trend CY 2021 Adjusted Experience to SFY 2024

Starting with the base data developed in Step 1, we apply trend adjustments to project the base period to SFY 2024. Below, we describe each trend adjustment shown on Exhibit 2. The adjustments for non-pharmacy and pharmacy services are developed using differing methodologies and, therefore, described separately in this section.

Non-Pharmacy Trend Overview

Our general approach to trend development for non-pharmacy categories of service is to consider expected changes in provider reimbursement along with historical PMPM trend values. We then develop utilization / service mix trends that produce targeted PMPM trends. We confirm the reasonability of the utilization trends against experience and assumptions from similar programs in other states. We utilize this approach because it is frequently difficult to directly measure changes in utilization for services, other than inpatient hospital and pharmacy over time, due to differences in counting utilization "units."

The following data sources were used to develop the trend assumptions:

- Encounter data and financial reporting experience for CHIP members to analyze PMPM and utilization trends by major service categories from CY 2017 through CY 2021. Exhibit 6 includes a historical trend summary for the CHIP program from CY 2017 through CY 2021. This includes encounter data from all three CCOs that have provided CHIP services over the time period shown and has been normalized for the following to put it on a consistent basis across time:
  - IBNR from the financial templates was added to the encounter data to review PMPM trends on a completed basis.
  - Estimates of the impact of the following material program or reimbursement changes were removed for the applicable time periods. These changes are accounted for in separate adjustments in this report and, therefore, should not be included in data analyzed for trends.
    - PDL changes
    - Provider settlements
  - Encounter data compared to the financial data for CHIP varies across time periods. Therefore, a high-level adjustment was applied to reflect the estimated difference between encounter data and financial data by calendar year (scaling encounters to financial data).
  - As shown in Table 3, the annualized PMPM trends on a normalized basis for the CHIP program averaged 1.0% from CY 2017 to CY 2019 prior to the beginning of the COVID-19 pandemic:

Table 3
Mississippi Division of Medicaid
CHIP Annualized PMPM Trends
January 2017 to December 2021

Category of Service	CY 2017 to CY 2018	CY 2018 to CY 2019	CY 2019 to CY 2020	CY 2020 to CY 2021
Inpatient Hospital	-3.9%	0.1%	11.8%	-7.4%
Outpatient Hospital	-4.9%	4.2%	-39.7%	14.5%
Physician	1.0%	4.6%	-20.4%	18.8%
Dental	0.0%	2.6%	-24.0%	11.1%
Other	7.2%	16.8%	-17.2%	15.1%
Non-Pharmacy Total	-1.8%	3.9%	-24.2%	11.9%

- Experience from similar programs in other states.

In addition, we carefully reviewed January to June 2022 experience reported by the CCOs to understand to what level services have returned to pre-pandemic levels.

We observe that starting during CY 2021 PMPM costs begin to increase and continue to increase steadily into CY 2022, approaching pre-COVID costs for the program as a whole. Therefore, when selecting prospective trend assumptions to apply from CY 2021 to SFY 2024 we relied primarily on pre-pandemic CHIP data, as well as data from other similar programs.

Utilization and unit charge adjustments are shown in rows (c) and (d), respectively, on Exhibit 2.

Prescription Drug Utilization and Unit Cost Trends

We developed pharmacy trends using the following sources:

- ***CHIP Pharmacy Data*** – We analyzed January 2021 to December 2021 pharmacy experience for the CHIP population and developed utilization and cost summaries by specialty and traditional (i.e., non-specialty) drug types, for the 22 top specialty therapeutic classes and 26 top traditional therapeutic classes. We developed cost projections to SFY 2024 from CY 2021 experience. We validated that the selected trends were reasonable to use by reviewing the therapeutic class distribution and resulting trends compared to those selected for the MississippiCAN children.

  Considerations were made when reviewing prescription drug experience for the estimated impacts of changes in annual updates to the state's uniform PDL.

- ***Industry Research*** – We reviewed recent drug trend reports from PBMs to benchmark the prospective list price and utilization trends used in our detailed modeling of CHIP-specific data. Additionally, we conducted industry research to adjust trends for anticipated market events, including but not limited to, novel pipeline drug launches, patent loss / major generic launches, expanded treatable population for approved drugs (e.g., new indication or age expansion), changes in standard of care (e.g., major clinical guideline updates), drug mix in CHIP pharmacy experience, and the state's uniform PDL status and anticipated updates.

- ***FDA Drug Approvals*** – When developing prospective drug trends, we consider the FDA approval of various new therapies. Some of the therapies we expect to have higher frequency and / or cost include:

  - Adbry™
  - Apretude®
  - Auvelity®
  - Briumvi™
  - Cabenuva®
  - Cibinqo™
  - Dupixent® (label expansion)
  - Jaypirca®
  - Krazati®
  - Mounjaro®
  - Olumiant® (label expansion)
  - Orserdu®
  - Rinvoq® (label expansion)
  - Skyrizi® (label expansion)
  - Sotyktu®
  - Tezspire®
  - Tzield™
  - Vtama®

  However, building explicit additional trend into the capitation rate for these products is difficult due to a lack of information on expected pricing and uptake among the various populations. Therefore, we build in modest additional trend to reflect the expansion of new approvals for each population. We note, the historical experience reviewed in trend development also reflects the impact of FDA approvals that were new during those periods. For select high-cost pharmaceuticals we build explicit adjustments into the capitation rate, as outlined in Step 3, rather than incorporating into the pharmacy trend assumption.

Based on our analyses, we estimate annualized utilization and unit cost trends from CY 2021 to SFY 2024 shown in Table 4. The utilization trends shown in Table 4 include the indirect impact of the change in mix of products due to pure utilization trends.

Table 4 Mississippi Division of Medicaid Pharmacy Trends for CY 2021 to SFY 2024	
Annualized Unit Cost Trends	2.50%
Annualized Utilization Trend	1.00%

When developing prospective drug trends, no consideration was given for brand to generic shifts. These shifts are reflected separately as a change in the state PDL.

Rows (c) and (d) in Exhibit 2 includes the trend adjustments for the pharmacy services.

Seasonal Virus Trend Adjustment

As the COVID-19 global pandemic evolves, we continue to monitor COVID-19 costs associated with testing, treatment, and vaccinations. In addition, we monitor costs associated with other seasonal viruses, including influenza and respiratory syncytial virus (RSV). We queried historic costs associated with COVID-19, influenza, and RSV and compared them to expectations about seasonal viral loads in SFY 2024. The expected SFY 2024 influenza and RSV costs were projected using historical costs observed in CY 2018 and CY 2019 for the children population (this included CHIP, as well as the children rate cells from MississippiCAN). The expected SFY 2024 COVID-19 costs were projected based on CY 2021 observed costs by population removing any large spikes corresponding with emerging COVID-19 variants to approximate costs in a "steady-state" COVID-19 environment. Table 5 below shows the development of this adjustment. See Exhibit 9 for further information on the development on the seasonal virus trend adjustment.

Table 5 Mississippi Division of Medicaid CHIP Seasonal Virus Trend Adjustment	
CY 2021 Cost	$8.85
SFY 2024 Cost	$9.25
Adjustment	**$0.40**

Row (e) in Exhibit 2 shows the adjustment for the seasonal virus trend adjustment.

Step 3: Apply Program Change Adjustments

For SFY 2024, there are several program and reimbursement changes expected for CHIP relative to the base period of CY 2021.

Postpartum Coverage Extension

Per SB 2212, postpartum coverage expands from 60 days to 12 months in SFY 2024. Previously, members in CHIP were transitioned out of the program once the member was identified as pregnant. To adjust for this change in enrollment shifting and the additional postpartum coverage members will receive in SFY 2024, we queried detailed claim and enrollment records for those members that we identified as removed from the CHIP rate cell due to a pregnancy. We added these claims and enrollment records and adjusted the expected SFY 2024 costs accordingly. Table 6 below demonstrates the development of the population change factor.

Table 6 Mississippi Division of Medicaid Postpartum Extension Adjustment		
	CY 2021 Original Coverage Population	
(A)	Member Months	554,885
(B)	Total Allowed	$107,622,415
(C) = (B) / (A)	**Allowed PMPM**	**$193.95**
	CY 2021 Expanded Coverage Population	
(D)	Member Months	1,441
(E)	Total Allowed	$970,315
(F) = (E) / (D)	**Allowed PMPM**	**$673.36**
	CY 2021 Blended Population	
(G) = (A) + (D)	Member Months	556,326
(H) = (B) + (E)	Total Allowed	$108,592,731
(I) = (H) / (G)	**Allowed PMPM**	**$195.20**
(J) = (I) / (C)	**Postpartum Population Change Factor**	**1.006**

Row (f) in Exhibit 2 shows the adjustment for the seasonal virus trend adjustment.

Preferred Drug List Revisions

Updates are made to the state PDL annually and take effect on January 1 of each year. We estimated the impact of these changes using detailed modeling provided by Change Healthcare, who is contracted by DOM to regularly update and maintain the state PDL. In our reliance on the PDL modeling performed by Change Healthcare we reviewed the output of the models for reasonableness, but did not audit their analyses.

The modeling provided by Change Healthcare included drug-level analyses of expected utilization shifts and resulting changes to pharmacy expenditures on a gross of rebate basis. This modeling uses data from both FFS and MississippiCAN populations, so we cannot directly use the output for rate development. Therefore, we applied the change in gross costs on a percentage basis by therapeutic class to CHIP encounter data to develop program-specific impacts of PDL revisions. Separate PDL adjustments were developed for each population to account for the different mix of drugs used for each group.

Table 7 shows the estimated impact of PDL revisions. The full adjustment applied is a combination of the PDL changes from CY 2021 to SFY 2024.

Table 7 Mississippi Division of Medicaid PDL Adjustment		
	2021 to 2022	**2022 to 2023**
CHIP	0.978	0.998

Relative to prior years, PDL changes effective January 1, 2023 only impacted seven therapeutic classes. Table 8 displays all seven classes and outlines the shifting assumptions modeled by Change Healthcare for each class.

Table 8
Mississippi Division of Medicaid
January 2023 PDL Adjustments

Therapeutic Class	Utilization Shifts To	Utilization Shifts From	Modeled Shift	Estimated Increase (Decrease) in Gross Costs	% of Total PDL Change
Antidiabetics-Insulin	Toujeo	Tresiba	25%	(0.4%)	10.3%
Contraceptives-Vaginal	Phexxi P	Phexxi NP	300%	200.0%	-0.7%
Growth Hormone Agents	Genotropin	Norditropin Nutropin	10% 10%	1.3%	-9.7%
Miscellaneous-Carbaglu	Carglumic Acid	Carbaglu	100%	(17.5%)	3.1%
Resp-Beta Agonist Inhalers	Proventil HFA Ventolin HFA	Proair HFA	100%	(7.9%)	31.2%
Resp-Steroid Inhalers	Fluticasone Salmeterol	Advair Diskus	50%	(6.7%)	81.5%
Urinary Antispasmodic Agents	Myrbetriq	Oxybutynin Chloride Solifenacin Succinate Darifenacin Gemtesa	5% 25% 50% 30%	73.7%	-15.8%

The shifting assumptions developed by Change Healthcare are meant to reflect the best estimate for how utilization will shift as certain products change preferred status effective January 1, 2023, recognizing that a full shift will not happen immediately. The estimated change in gross cost assumes the ultimate modeled shift shown in Table 8 is achieved two quarters after the PDL changes take effect, and therefore, the January 2023 PDL updates will be applicable to all of SFY 2024.

The adjustment for PDL revisions is shown in row (g) of Exhibit 2.

Gene Therapy Coverage

There are several high-cost gene therapies that are currently available or will become available during SFY 2024. We worked closely with our clinical team and the clinical team at DOM to identify eligible members, potential treatment uptake percentages, and total costs for treatment for each gene therapy. Ultimately, we included an estimate for a treatment for Hemophilia B. Table 9 below details the assumptions for this treatment.

Table 9
SFY 2024 CHIP Capitation Rate Development
Gene Therapy Estimates

Condition	Gene Therapy	Number of Treatments	Pharmacy Cost per Treatment	Inpatient Cost per Treatment
Hemophilia B	Hemgenix	1	$3,500,000	$0

Row (h) in Exhibit 2 shows this adjustment.

Gene Therapy Coverage Savings

The gene therapy listed above is assumed to significantly reduce or eliminate symptoms of the underlying condition. We queried CY 2021 claims data for potential utilizers meeting the clinical profile for Hemgenix. We worked closely with our clinical team to determine, which costs associated with the Hemophilia B are likely to be alleviated and calculated assumed annual savings amounts for potential utilizers of this treatment. We assumed a uniform distribution of uptake throughout SFY 2024 and applied the relevant portion of the annual savings in the adjustment. For Hemophilia B, we assume about $106,000 in medical savings per member as a result of this treatment.

Row (i) in Exhibit 2 shows this adjustment.

Insulin Price Reduction

Starting on January 1, 2024 the American Rescue Plan Act of 2021 removes the limit, or "cap," on Medicaid drug rebates, which are currently capped at the average manufacturer price (AMP). Several insulin manufacturers have announced price decreases related to the removal starting as early as Q3 2023, with most prices decreasing January1, 2024. We pulled CY 2021 insulin claims at the NDC level and repriced these claims at the announced new price accounting for the timing of each price reduction throughout SFY 2024. Please see Exhibit 12 for a list of insulin products and their price reduction.

Row (j) in Exhibit 2 shows this adjustment.

Step 4: Provide an Allowance for CCO Non-Service Expenses

Administrative Expenses, Premium Tax, and Targeted Margin

The administrative allowance included in the capitation rate is intended to cover the following costs:

- Case management
- Utilization management
- Claim processing and other IT functions
- Customer service
- Provider contracting and credentialing
- Third party liability and program integrity
- Member grievances and appeals
- Financial and other program reporting
- Local overhead costs
- Corporate overhead and business functions (e.g., legal, executive, human resources)

The non-service expense allowance for the SFY 2024 capitation rate is comprised of a flat PMPM for fixed administrative costs and a percentage of revenue for variable administrative costs. We also included explicit adjustments of 1.80% of revenue for target margin and 3.00% for the Mississippi premium tax, for a total non-service expense allowance of 14.55%. Table 10 displays the allowance included in the CHIP rate for non-service expenses.

Table 10
Mississippi Division of Medicaid
Non-Service Expenses

	% of Revenue	PMPM
Fixed Costs[1]	2.93%	$7.63
Variable Costs[2]	6.83%	$17.80
Premium Tax[2]	3.00%	$7.82
Margin[2]	1.80%	$4.69
Total	14.55%	$37.95

[1] Included in the rate as a PMPM, equivalent % of revenue shown.
[2] Included in the rate as a % of revenue, equivalent PMPM is shown.

The administrative expense allowance for SFY 2024 was developed by trending the fixed and variable allowances from CY 2021 financial data provided by the CCOs, adjusted for the results of administrative expense audits by Myers and Stauffer. Administrative expenses were trended by an average 3.8% increase per year. The 3.8% annual trend is a blend of actual employment cost index (ECI) data from CY 2021 through CY 2022 and an assumed 3.0% annual trend from CY 2022 to SFY 2024. The future 3.0% trend assumption is consistent with the average ECI annual change from CY 2018 through CY 2021. The ECI data reflects expected changes in wages and other services that comprise a majority of administrative costs.

Step 5: Calculate Risk Corridor Settlements

Subject to CMS approval, DOM will implement two symmetrical risk corridors to address the uncertainty of medical costs given the unwinding of the COVID-19 PHE during SFY 2024 and the uncertainty of several current and anticipated high-cost medications.

High-Cost Pharmacy Risk Corridor

Some Medicaid members have conditions requiring very expensive drug treatments. These members are infrequent and not evenly distributed among the CCOs. To help mitigate the CCO's risk, the state is introducing a high-cost pharmacy risk corridor for SFY 2024, subject to CMS approval. The risk corridor is applicable to total drug spend and related costs due to administration and monitoring for specified products of $500,000 or more per year at a member level. The capitation rate includes a $5.37 PMPM estimate of the costs that will be covered in the high-cost pharmacy risk corridor specific to the CHIP rate cell. Please see Exhibit 13A and Exhibit 13B for the detailed calculation of the $5.37 PMPM target. The actual costs from the CCOs will be compared to the estimated cost for the settlement calculations.

Table 11 summarizes the share of gains and losses relative to the estimated high-cost pharmacy costs for each party.

Table 11
Mississippi Division of Medicaid
Proposed High-Cost Pharmacy Risk Corridor Parameters

CCO Gain / Loss	CCO Share of Gain / Loss in Corridor	DOM Share of Gain / Loss in Corridor
Less than -6.0%	0%	100%
-6.0% to -3.0%	50%	50%
-3.0% to +3.0%	100%	0%
+3.0% to +6.0%	50%	50%
Greater than +6.0%	0%	100%

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

- Estimated high-cost pharmacy costs are calculated separately for the CHIP rate cell based on the expected mix of high-cost products.
- The CHIP rate cell's actual high-cost pharmacy costs will include payments made for the following:
  - All pharmacy claims with an NDC code billed through a retail or specialty pharmacy, regardless of where these claims are administered.
  - All drugs billed as medical claims with a HCPCS code that starts with the letter "J."
  - Inpatient stays for the administration and monitoring for select gene therapies and other select products. The estimated pharmacy costs included in the high-cost risk corridor include the following; however, DOM will monitor and revise the list of approved products if additional products are covered by DOM for use during SFY 2024.
    - Lovotibeglogene autotemcel (lovo-cel)
    - Exagamglogene autotemcel (exa-cel)
    - Zynteglo
- The timing of the risk corridor settlements will occur during the initial and final settlements for the program-wide risk corridor. The high-costs pharmacy risk corridor will be calculated independent of the larger program-wide risk corridor.
  - The initial settlement will occur after the contract year is closed, using six months of runout.
  - The final settlement will occur once the MLR audit has been completed. MLR audits are usually completed 12 to 18 months after the close of the SFY.

The 85% minimum MLR provision (Federal MLR definition) in the CCO contract will apply after the risk corridor settlement calculation.

Program-Wide Risk Corridor

The capitation rate in this report reflects a target medical loss ratio (MLR), which measures the projected medical service costs as a percentage of the total capitation rate paid to the CCOs less the cost eligible for the high-cost pharmacy risk corridor. The risk corridor would limit CCO gains and losses if the actual MLR is different than the target MLR. Table 12 summarizes the share of gains and losses relative to the target MLR for each party.

Table 12
Mississippi Division of Medicaid
Proposed Risk Corridor Parameters

MLR Claims Corridor	CCO Share of Gain / Loss in Corridor	DOM Share of Gain / Loss in Corridor
Less than Target MLR -2.0%	0%	100%
Target MLR -2.0% to Target MLR +2.0%	100%	0%
Greater than Target MLR +2.0%	0%	100%

For the purposes of the SFY 2024 program-wide risk corridor, a different definition of MLR will be used than the Federal MLR definition. The last column of Exhibit 3 illustrates the calculation of the target MLR for each CCO. The final target MLR will not vary by CCO.

The program-wide risk corridor will be implemented using the following provisions:

- Actual and target MLRs will be calculated separately for each CCO based on their actual enrollment mix.
- The numerator of each CCO's actual MLR will include state plan covered services incurred during the period of SFY 2024 with payments made to providers as defined in Exhibit D of the CCO Contract, including fee for-service payments, subcapitation payments, and settlement payments. Non-covered services will be removed from the numerator.
- The high-costs pharmacy risk corridor will be calculated independent of the larger program-wide risk corridor.
- Adjustments to revenue and claims resulting from the MLR audit will be incorporated into the calculation of each CCO's actual MLR.

The program-wide risk corridor settlement will occur after the contract year is closed, using six months of runout. An initial calculation will occur, but the final calculation will occur once the MLR audit has been completed. MLR audits are usually completed 12 to 18 months after the close of the SFY.

Other Program Considerations

Minimum MLR

The program includes a minimum MLR requirement of 85% of revenue. The sum of medical expenses and HCQI expenses must meet or exceed 85% of revenue. Revenue for premium taxes is excluded from the MLR calculation. If the 85% threshold is not met, CCOs return revenue to DOM until the threshold is met. Due to the implementation of a 2% risk corridor for SFY 2024, the minimum MLR will be greater than 85% and not trigger any additional payments as of a result of this provision.

Withholds

There are no withholds associated with the CHIP capitation rate.

Risk Adjustment

The SFY 2024 CHIP capitation rate will not be risk adjusted.

EXHIBITS 1 THROUGH 13B

(Provided in Excel Format Only)

APPENDIX A

Data Processing

APPENDIX B

Actuarial Certification of the SFY 2024 CHIP Capitation Rate

APPENDIX C

Data Reliance Letter

This report assumes the reader is familiar with the State of Mississippi's CHIP program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set the SFY 2024 capitation rate for the CHIP program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

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Caveats and Limitations
Mississippi Division of Medicaid
READ BEFORE PROCEEDING

Milliman has developed certain models to estimate the values included in these exhibits and appendices. The intent of the models was to estimate SFY 2024 capitation rates. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We used CCO encounter data and CCO financial exhibits and appendicesing from January 2021 to December 2021 with runout through April 2022, historical and projected reimbursement information, TPL recoveries, fee schedules, pharmacy and dispensing fee pricing, and other information from DOM, CHIP CCOs, Myers and Stauffer, Change Healthcare, and CMS to calculate the preliminary CHIP capitation rates shown in these exhibits and appendices. If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete. Please see Appendix E for a full list of the data relied upon to develop the SFY 2024 capitation rates.

Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Our exhibits and appendices are intended for the internal use of DOM to review preliminary CHIP capitation rates for SFY 2024. The exhibits and appendices and the models used to develop the values in these exhibits and appendices may not be appropriate for other purposes. We anticipate the exhibits and appendices will be shared with contracted CCOs, CMS and other interested parties. Milliman does not intend to service, and assumes no duty or liability to, other parties who receive this work. It should only be distributed and reviewed in its entirety. These capitation rates may not be appropriate for all CCOs. Any CCO considering participating in CHIP should consider their unique circumstances before deciding to contract under these rates.

The results of these exhibits and appendices are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

The authors of these exhibits and appendices are actuaries employed by Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, these exhibits and appendices are complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

Exhibit 1
Mississippi Division of Medicaid
All Regions SFY 2024 CHIP Capitation Rate Development
Base Data
All Children

Calculation Step	PMPM Development	Category of Service						
		Inpatient Hospital	Outpatient Hospital	Physician	Drug	Dental	Other	Total
a	CY 2021 Member Months	554,885	554,885	554,885	554,885	554,885	554,885	
b	Total Paid Dollars	$11,781,883	$24,958,510	$33,059,782	$21,869,793	$14,335,134	$2,520,046	**$108,525,148**
c = b / a	CY 2021 PMPM Costs	$21.23	$44.98	$59.58	$39.41	$25.83	$4.54	**$195.58**
d	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	0.996	**1.000**
e	TPL Adjustment	0.999	0.999	0.999	0.999	0.999	0.999	**0.999**
f	Drug Services Rebate Adjustment	1.000	1.000	1.000	0.930	1.000	1.000	**0.986**
g	IBNR Adjustment	1.003	1.004	1.002	1.000	1.002	1.002	**1.002**
h	Missing Data	1.003	1.005	1.004	1.005	1.005	1.006	**1.005**
i = Product of c through h	Adjusted CY 2021 PMPM Costs	$21.35	$45.36	$59.89	$36.81	$25.99	$4.55	**$193.95**

Exhibit 2
Mississippi Division of Medicaid
All Regions SFY 2024 CHIP Capitation Rate Development
Projection Assumptions
All Children

Calculation Step	PMPM Development	Category of Service						
		Inpatient Hospital	Outpatient Hospital	Physician	Drug	Dental	Other	Total
a	SFY 2024 Member Months	512,655	512,655	512,655	512,655	512,655	512,655	**512,655**
b	Adjusted CY 2021 PMPM Costs	$21.35	$45.36	$59.89	$36.81	$25.99	$4.55	**$193.95**
c	Utilization Trend Factors CY 2021 to SFY 2024	1.077	1.156	1.156	1.025	1.000	1.156	**1.102**
d	Charge Trend Factors CY 2021 to SFY 2024	1.000	1.000	1.000	1.064	1.000	1.000	**1.011**
e	Seasonal Virus Adjustment	1.001	1.003	1.003	1.001	1.000	1.000	**1.002**
f	Postpartum Coverage Extension	1.006	1.006	1.006	1.006	1.006	1.006	**1.006**
g	PDL Adjustment	1.000	1.000	1.000	0.975	1.000	1.000	**0.995**
h	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.173	1.000	1.000	**1.031**
i	Gene Therapy Drug Coverage Savings	1.000	1.000	1.000	0.996	1.000	1.000	**0.999**
j	Insulin Price Reduction	1.000	1.000	1.000	0.986	1.000	1.000	**0.997**
k = Product of b through j	Projected SFY 2024 PMPM Costs	$23.17	$52.92	$69.90	$45.42	$26.16	$5.30	**$222.86**

Exhibit 3
Mississippi Division of Medicaid
SFY 2024 CHIP Capitation Rate Development
Non-Service Expense Allowance Development

Rate Cell	a SFY 2024 PMPM Cost	b Fixed Non-Service Expense Load	c Non-Service Percentage	d = c × i Non-Service PMPM	e Margin Percentage	f = e × i Margin PMPM	g Premium Tax Percentage	h = g × i Premium Tax PMPM	i = (a + b) / (1 - c - e - g) Total	j = a / i Illustrative Target MLR[1]
All Children	$222.86	$7.63	6.83%	$17.80	1.80%	$4.69	3.00%	$7.82	$260.82	85.4%

[1] *Includes all services incurred during SFY 2024 with payments made to providers as defined in Exhibit C of the CCO Contract, including fee-for-service payments, subcapitation payments, and settlement payments. Actual MLR, but not target MLR, will be populated with actual SFY 2024 CCO-specific values. Actual MLR will include adjustments for items found in MLR audits and adjustments to remove services not covered by the Mississippi state plan.*

Exhibit 4A
Mississippi Division of Medicaid
SFY 2024 CHIP Capitation Rate Development
High-Cost Pharmacy Risk Corridor
Illustrative Settlement Calculation

Rate Cell	*a* Illustrative Actual SFY 2024 Membership[1]	*b* SFY 2024 High-Cost Pharmacy Target PMPM[2]	*c* Illustrative Actual SFY 2024 High-Cost Pharmacy Costs[3]	*d = c / a* Illustrative Actual SFY 2024 High-Cost Pharmacy PMPM
CHIP	513,000	$5.37	$3,250,000	$6.34

Illustrative Actual Risk Corridor Eligible Costs	$3,250,000	**e = c**
Illustrative Target Risk Corridor Eligible Costs	$2,753,176	**f = b x a**
Difference ($)	$496,824	**g = e - f**
Difference (%)	18.05%	**h = g / f**

Risk Corridor Bands	**%** **i**	**$** **j = i × f**	**Settlement** **k = j × CCO %**
< -6%: 0% CCO / 100% DOM	0.00%	$0	$0
-6% to -3%: 50% CCO / 50% DOM	0.00%	$0	$0
-3% to 0%: 100% CCO / 0% DOM	0.00%	$0	$0
0% to 3%: 100% CCO / 0% DOM	3.00%	$82,595	$0
3% to 6%: 50% CCO / 50% DOM	3.00%	$82,595	($41,298)
> 6%: 0% CCO / 100% DOM	12.05%	$331,634	($331,634)
Total Risk Corridor Settlement Received (Paid) by DOM			**($372,932)**

[1] Illustrative values demonstrate projected regional enrollment mix. Actual values will use CCO-specific regional enrollment mix.
[2] PMPM calculation will be populated with actual SFY 2024 CCO-specific values
[3] Includes all costs incurred during SFY 2024 eligible for the risk corridor, as outlined in the rate certification. Actual MLR, but not target MLR, will be populated with actual SFY 2024 CCO-specific values. Actual MLR will include adjustments for items found in MLR audits and adjustments to remove services not covered by the CHIP program.
[4] Costs and premiums associated with the High-Cost Pharmacy Risk Corridor will not be accounted for or included in the calculation of the Program-Wide Risk Corridor.

Exhibit 4B
Mississippi Division of Medicaid
SFY 2024 CHIP Capitation Rate Development
Illustrative MLR Development

Rate Cell	a Projected SFY 2024 Membership	b SFY 2024 Capitation Rate[1]	c SFY 2024 High-Cost Pharmacy Target PMPM	d Illustrative High-Cost Pharmacy Actual SFY 2024 PMPM	e Illustrative Actual SFY 2024 Medical Costs PMPM[2]	f=e-d Illustrative Actual SFY 2024 Total Service Costs PMPM	g=f/(b-c) Illustrative Actual MLR	h Projected SFY 2024 Medical Costs PMPM[2]	i=h-c Projected SFY 2024 Total Service Costs PMPM	j=i/(b-c) Illustrative Target MLR
CHIP	256,300	$260.82	$5.37	$6.34	$200.00	$193.66	75.81%	$222.86	$217.50	85.14%

Illustrative Actual MLR	75.81%
Illustrative Target MLR	85.14%
MLR Difference	9.33%
MLR Difference Exceeding Corridor	7.33%
Total Revenue[4]	$65,471,699
Risk Corridor Settlement Received (Paid) by DOM	$4,798,854

[1] Revenue is not reduced for taxes or assessments.

[2] Includes all services incurred during SFY 2024 with payments made to providers as defined in Exhibit C of the CCO Contract, including fee-for-service payments, medical components of subcapitation payments, and settlement payments. Excluded expenses include non-covered or enhanced services, administrative or profit components of subcapitation payments, and quality improvement expenses. Expenses will be reduced for CCO pharmacy rebates. Calculations will be performed using six months of runout and will include IBNR estimates of remaining SFY 2024 incurred claims.

[3] Costs and premiums associated with the High-Cost Pharmacy Risk Corridor will not be accounted for or included in the calculation of the Program-Wide Risk Corridor.

[4] Excluding high-cost pharmacy target PMPM.

Exhibit 5
Mississippi Division of Medicaid
SFY 2024 CHIP Capitation Rate Development
Service Category to Milliman *HCGs* Grouper Category Mapping

MR Line	Broad Category of Service	Description
I11a	Inpatient Hospital	Medical
I11b	Inpatient Hospital	Rehabilitation
I12	Inpatient Hospital	Surgical
I13a	Inpatient Hospital	Psychiatric - Hospital
I13b	Inpatient Hospital	Psychiatric - Residential
I14a	Inpatient Hospital	Substance Use Disorders - Hospital
I14b	Inpatient Hospital	Substance Use Disorders - Residential
I21a	Inpatient Hospital	Mat Norm Delivery
I21b	Inpatient Hospital	Mat Norm Delivery - Mom\Baby Cmbnd
I22a	Inpatient Hospital	Mat Csect Delivery
I22b	Inpatient Hospital	Mat Csect Delivery - Mom\Baby Cmbnd
I23a	Inpatient Hospital	Well Newborn - Normal Delivery
I23b	Inpatient Hospital	Well Newborn - Csect Delivery
I23c	Inpatient Hospital	Well Newborn - Unknown Delivery
I24	Inpatient Hospital	Other Newborn
I25	Inpatient Hospital	Maternity Non-Delivery
I31	Inpatient Hospital	SNF
O10a	Outpatient Hospital	Observation - Without ED
O10b	Outpatient Hospital	Observation - With ED
O11	Outpatient Hospital	Emergency Department
O12a	Outpatient Hospital	Surgery - Hospital Outpatient
O12b	Outpatient Hospital	Surgery - Ambulatory Surgery Center
O13a	Outpatient Hospital	Radiology General - Therapeutic
O13b	Outpatient Hospital	Radiology General - Diagnostic
O14a	Outpatient Hospital	Radiology - CT/MRI/PET - CT Scan
O14b	Outpatient Hospital	Radiology - CT/MRI/PET - MRI
O14c	Outpatient Hospital	Radiology - CT/MRI/PET - PET
O15	Outpatient Hospital	Pathology/Lab
O16a	Outpatient Hospital	Pharmacy - General
O16b	Outpatient Hospital	Pharmacy - Chemotherapy
O17	Outpatient Hospital	Cardiovascular
O18	Outpatient Hospital	PT/OT/ST
O31a	Outpatient Hospital	Psychiatric - Partial Hospitalization
O31b	Outpatient Hospital	Psychiatric - Intensive Outpatient
O32a	Outpatient Hospital	Substance Use Disorders - Partial Hospitalization
O32b	Outpatient Hospital	Substance Use Disorders - Intensive Outpatient
O41a	Outpatient Hospital	Other - General
O41b	Outpatient Hospital	Other - Blood
O41d	Outpatient Hospital	Other - Clinic
O41e	Outpatient Hospital	Other - Diagnostic
O41f	Outpatient Hospital	Other - Dialysis
O41g	Outpatient Hospital	Other - DME/Supplies
O41h	Outpatient Hospital	Other - Trtmt/SpcltySvcs
O41j	Outpatient Hospital	Other - Pulmonary
O41l	Outpatient Hospital	Other - Urgent Care
O51a	Outpatient Hospital	Preventive - General
O51b	Outpatient Hospital	Preventive - Colonoscopy
O51c	Outpatient Hospital	Preventive - Mammography
O51d	Outpatient Hospital	Preventive - Lab
P11	Physician	Inpatient Surgery
P13	Physician	Inpatient Anesthesia
P14	Physician	Outpatient Surgery
P15	Physician	Office Surgery
P16	Physician	Outpatient Anesthesia
P21a	Physician	Maternity - Normal Deliveries
P21b	Physician	Maternity - Cesarean Deliveries
P21c	Physician	Maternity - Non-Deliveries
P21d	Physician	Maternity - Ancillary
P21e	Physician	Maternity - Anesthesia
P31d	Physician	Inpatient Visits - Medical
P31e	Physician	Inpatient Visits - Psychiatric
P31f	Physician	Inpatient Visits - Substance Use Disorders
P32c	Physician	Office/Home Visits - PCP
P32d	Physician	Office/Home Visits - Specialist
P33	Physician	Urgent Care Visits
P34a	Physician	Office Administered Drugs - General
P34b	Physician	Office Administered Drugs - Chemotherapy
P35	Physician	Allergy Testing
P36	Physician	Allergy Immunotherapy
P37a	Physician	Miscellaneous Medical - General
P37b	Physician	Miscellaneous Medical - Gastroenterology
P37c	Physician	Miscellaneous Medical - Ophthalmology
P37d	Physician	Miscellaneous Medical - Otorhinolaryngology
P37e	Physician	Miscellaneous Medical - Vestibular Function Tests
P37f	Physician	Miscellaneous Medical - Non-Invas. Vasc. Diag. Studies
P37g	Physician	Miscellaneous Medical - Pulmonology
P37h	Physician	Miscellaneous Medical - Neurology
P37i	Physician	Miscellaneous Medical - Central Nervous System Tests
P37j	Physician	Miscellaneous Medical - Dermatology
P37k	Physician	Miscellaneous Medical - Dialysis

MR Line	Broad Category of Service	Description
P40a	Physician	Preventive Other - General
P40b	Physician	Preventive Other - Colonoscopy
P40c	Physician	Preventive Other - Mammography
P40d	Physician	Preventive Other - Lab
P41	Physician	Preventive Immunizations
P42	Physician	Preventive Well Baby Exams
P43	Physician	Preventive Physical Exams
P44	Physician	Vision Exams
P45	Physician	Hearing and Speech Exams
P51a	Physician	ED Visits and Observation Care - Observation Care
P51b	Physician	ED Visits and Observation Care - ED Visits
P53	Physician	Physical Therapy
P54	Physician	Cardiovascular
P55b	Physician	Radiology IP - CT Scan
P55c	Physician	Radiology IP - MRI
P55d	Physician	Radiology IP - PET
P55e	Physician	Radiology IP - General - Therapeutic
P55f	Physician	Radiology IP - General - Diagnostic
P56a	Physician	Radiology OP - General - Therapeutic
P56b	Physician	Radiology OP - General - Diagnostic
P57a	Physician	Radiology OP- CT/MRI/PET - CT Scan
P57b	Physician	Radiology OP- CT/MRI/PET - MRI
P57c	Physician	Radiology OP- CT/MRI/PET - PET
P58c	Physician	Radiology Office - General - Therapeutic
P58d	Physician	Radiology Office - General - Diagnostic
P58e	Physician	Radiology Office - General - Radiology Center - Therapeutic
P58f	Physician	Radiology Office - General - Radiology Center - Diagnostic
P59a	Physician	Radiology Office - CT/MRI/PET - CT Scan
P59b	Physician	Radiology Office - CT/MRI/PET - MRI
P59c	Physician	Radiology Office - CT/MRI/PET - PET
P59d	Physician	Radiology Office - CT/MRI/PET - CT Scan - Radiology Center
P59e	Physician	Radiology Office - CT/MRI/PET - MRI - Radiology Center
P59f	Physician	Radiology Office - CT/MRI/PET - PET - Radiology Center
P61a	Physician	Pathology/Lab - Inpatient & Outpatient - Inpatient
P61b	Physician	Pathology/Lab - Inpatient & Outpatient - Outpatient
P63a	Physician	Pathology/Lab - Office - General
P63b	Physician	Pathology/Lab - Office - Venipuncture
P63c	Physician	Pathology/Lab - Office - Independent Lab
P65	Physician	Chiropractor
P66	Physician	Outpatient Psychiatric
P67	Physician	Outpatient Substance Use Disorders
P82c	Other	Home Health Care - Home Health (Medicare Covered)
P82d	Other	Home Health Care - Hospice - Home Based
P82e	Other	Home Health Care - Hospice - Facility Based
P82f	Other	Home Health Care - Home Health (Not Medicare Covered)
P82g	Other	Home Health Care - Personal/Custodial Care
P82h	Other	Home Health Care - Adult Day Health Care
P82i	Other	Home Health Care - Home Respite Care
P82j	Other	ome Health Care - Personal Emergency Response System (PER:
P82k	Other	Home Health Care - Home Modification
P82l	Other	Home Health Care - Home Delivered Meals
P82m	Other	Home Health Care - Assisted Living Facility
P82n	Other	Home Health Care - Ancillary Services Provided in the Home
P83	Other	Ambulance
P84	Other	DME and Supplies
P85	Other	Prosthetics
P89	Other	Benefits Glasses/Contacts
P99a	Other	Benefits Other - General
P99b	Other	Benefits Other - Hearing Aids
P99c	Dental	Benefits Other - Dental
P99d	Other	Benefits Other - Acupuncture
P99e	Physician	Benefits Other - Reproductive Medicine
P99f	Physician	Benefits Other - Temporary Codes
P99g	Physician	Benefits Other - Documentation
P99h	Other	Benefits Other - Non-Emergency Transportation
P99z	Physician	Benefits Other - Unclassified
R73a	Drug	Prescription Drugs - Preferred Generic
R73b	Drug	Prescription Drugs - Non-Preferred Generic
R74a	Drug	Prescription Drugs - Preferred Brand
R74b	Drug	Prescription Drugs - Non-Preferred Brand
R75	Drug	Prescription Drugs - Specialty
R76	Drug	Prescription Drugs - Preventive
P81a	Drug	Prescription Drugs - Non-Specialty Generic
P81b	Drug	Prescription Drugs - Non-Specialty Multi Source Brand
P81c	Drug	Prescription Drugs - Non-Specialty Single Source Brand
P81e	Drug	Prescription Drugs - OTC
P81g	Drug	Prescription Drugs - Specialty
P82a	Other	Home Health Care - HH
P82b	Other	Home Health Care - Hospice

Exhibit 6
Mississippi Division of Medicaid
CHIP Historical Completed Non-Pharmacy PMPM Costs and Trends

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2017	48,537	$18.85	$63.34	$60.74	$31.99	$3.67	$178.59
February 2017	48,567	$19.19	$63.02	$64.46	$28.15	$3.28	$178.10
March 2017	48,536	$16.97	$67.22	$64.22	$32.92	$3.93	$185.26
April 2017	48,589	$18.71	$61.66	$55.56	$27.27	$3.75	$166.94
May 2017	48,833	$14.35	$60.21	$54.12	$26.77	$3.10	$158.54
June 2017	48,920	$56.33	$60.34	$52.85	$32.98	$4.06	$208.57
July 2017	49,018	$22.48	$65.77	$57.10	$35.70	$4.66	$185.71
August 2017	48,677	$20.35	$67.18	$67.41	$33.30	$4.16	$192.40
September 2017	48,415	$15.47	$72.12	$58.33	$26.93	$3.95	$176.80
October 2017	47,962	$19.72	$73.84	$66.62	$31.26	$4.43	$195.87
November 2017	47,990	$17.00	$76.29	$67.06	$28.60	$3.62	$192.57
December 2017	47,872	$17.61	$72.05	$60.96	$26.24	$3.64	$180.51
CY 2017[2]	**48,493**	**$21.59**	**$66.92**	**$60.79**	**$30.18**	**$3.85**	**$183.32**
January 2018	47,842	$22.69	$72.23	$64.89	$31.52	$3.66	$194.99
February 2018	47,715	$21.87	$73.91	$68.98	$29.65	$3.25	$197.66
March 2018	47,608	$26.36	$67.38	$60.46	$33.39	$4.23	$191.83
April 2018	47,236	$9.76	$65.09	$59.21	$28.99	$3.82	$166.86
May 2018	46,806	$18.98	$67.33	$57.22	$27.11	$3.70	$174.34
June 2018	46,809	$13.25	$57.65	$49.29	$32.85	$3.42	$156.46
July 2018	46,526	$27.19	$55.20	$61.34	$37.85	$4.73	$186.31
August 2018	46,560	$27.09	$62.56	$65.54	$33.17	$4.89	$193.25
September 2018	46,583	$19.17	$54.17	$59.33	$25.84	$3.86	$162.37
October 2018	46,382	$22.31	$64.95	$73.68	$31.26	$4.95	$197.15
November 2018	46,479	$26.31	$58.22	$63.39	$27.50	$5.20	$180.62
December 2018	46,569	$13.87	$64.82	$53.27	$23.10	$3.84	$158.89
CY 2018[3]	**46,926**	**$20.74**	**$63.63**	**$61.38**	**$30.19**	**$4.13**	**$180.06**
January 2019	46,619	$16.06	$78.13	$72.60	$34.56	$5.34	$206.68
February 2019	46,748	$21.65	$75.46	$76.31	$30.37	$4.03	$207.82
March 2019	46,711	$14.79	$71.10	$65.05	$32.19	$5.04	$188.17
April 2019	46,719	$16.50	$68.97	$64.19	$31.99	$4.57	$186.22
May 2019	46,730	$22.36	$66.50	$59.30	$27.69	$4.73	$180.58
June 2019	46,528	$16.35	$62.39	$50.67	$30.96	$4.25	$164.62
July 2019	46,487	$32.99	$61.90	$62.83	$39.44	$5.70	$202.85
August 2019	46,649	$23.90	$58.45	$64.20	$32.00	$5.76	$184.30
September 2019	46,583	$14.76	$66.41	$61.57	$28.08	$4.87	$175.70
October 2019	46,465	$20.50	$69.59	$69.58	$34.26	$6.02	$199.95
November 2019	46,293	$29.91	$58.15	$64.43	$26.08	$4.17	$182.75
December 2019	46,374	$19.43	$58.42	$59.56	$24.17	$3.38	$164.96
CY 2019[3]	**46,576**	**$20.77**	**$66.29**	**$64.19**	**$30.98**	**$4.82**	**$187.05**
January 2020	46,636	$35.03	$60.30	$67.77	$31.60	$4.21	$198.90
February 2020	46,806	$20.77	$55.47	$66.90	$27.64	$3.90	$174.67
March 2020	46,820	$15.49	$39.58	$47.33	$19.21	$4.18	$125.79
April 2020	47,503	$11.47	$16.41	$24.86	$1.46	$2.37	$56.57
May 2020	48,078	$23.69	$29.10	$36.73	$15.80	$3.55	$108.87
June 2020	48,398	$31.07	$39.41	$47.75	$29.53	$3.54	$151.30
July 2020	48,035	$17.72	$41.14	$52.88	$31.18	$5.03	$147.95
August 2020	48,161	$26.07	$38.39	$50.01	$26.18	$4.62	$145.27
September 2020	48,266	$35.01	$39.15	$54.88	$26.10	$4.15	$159.28
October 2020	48,275	$20.93	$41.21	$58.20	$25.90	$4.55	$150.81
November 2020	48,321	$31.25	$38.58	$54.64	$23.13	$4.12	$151.72
December 2020	48,321	$10.15	$41.25	$50.82	$24.68	$3.69	$130.59
CY 2020[3]	**47,802**	**$23.22**	**$40.00**	**$51.06**	**$23.54**	**$3.99**	**$141.81**
January 2021	48,285	$23.38	$36.69	$52.62	$25.81	$4.08	$142.58
February 2021	48,204	$12.49	$34.30	$46.01	$21.91	$4.12	$118.83
March 2021	48,026	$27.35	$41.28	$55.86	$32.00	$4.97	$161.57
April 2021	47,885	$20.15	$45.64	$58.69	$27.71	$5.57	$157.75
May 2021	47,833	$19.45	$46.80	$51.80	$21.93	$4.28	$144.27
June 2021	47,666	$27.80	$47.55	$53.78	$27.75	$4.66	$161.53
July 2021	46,953	$21.76	$50.93	$62.31	$29.03	$5.00	$169.03
August 2021	45,982	$24.29	$51.14	$79.99	$24.28	$4.46	$184.17
September 2021	45,128	$22.05	$45.79	$67.52	$26.50	$4.60	$166.45
October 2021	43,501	$28.40	$50.03	$66.38	$25.87	$4.80	$175.48
November 2021	42,894	$16.88	$52.20	$68.26	$26.86	$4.52	$168.71
December 2021	42,528	$14.03	$47.36	$64.40	$24.18	$4.09	$154.07
CY 2021[3]	**46,240**	**$21.50**	**$45.81**	**$60.64**	**$26.15**	**$4.60**	**$158.70**

Annual PMPM Trends

CY 2017 to CY 2018	-3.9%	-4.9%	1.0%	0.0%	7.2%	-1.8%
CY 2018 to CY 2019	0.1%	4.2%	4.6%	2.6%	16.8%	3.9%
CY 2019 to CY 2020	11.8%	-39.7%	-20.4%	-24.0%	-17.2%	-24.2%
CY 2020 to CY 2021	-7.4%	14.5%	18.8%	11.1%	15.1%	11.9%
CY 2019 to CY 2021 (Annualized)	1.8%	-16.9%	-2.8%	-8.1%	-2.4%	-7.9%

[1] CHIP PMPM figures have been adjusted for: annual PDL changes to drug costs, provider settlements, financial to encounter adjustments, and IBNR.
[2] CY 2016, CY 2018, CY 2019, and CY 2020 assumed to be fully complete with no explicit IBNR adjustment.
[3] CY 2021 IBNR as reported by CCOs in financial templates.

Exhibit 7A
Mississippi Division of Medicaid
CHIP Program
Traditional Rx Trends by Therapeutic Class

Drug Class	PMPM Cost		Annualized CY 2021 to SFY 2024 Trend		
	CY 2021	SFY 2024	Utilization	Unit Cost	PMPM
Antiasthmatic and COPD Agents	$3.65	387.6%	$0.01	$0.01	2.4%
Anticoagulants	$0.01	1.3%	$0.04	$0.04	8.2%
Anticonvulsants	$0.64	67.6%	$0.03	($0.01)	2.3%
Antidepressants	$0.27	31.2%	$0.04	$0.02	5.7%
Antihistamines and Respiratory Agents	$1.09	109.8%	$0.01	($0.01)	0.2%
Anti-Infective Agents	$1.86	174.3%	$0.00	($0.03)	-2.7%
Antipsychotic	$0.52	58.4%	$0.05	($0.00)	4.8%
Cardiovascular	$0.29	30.5%	$0.02	$0.00	2.1%
Contraceptives	$0.93	94.8%	$0.01	$0.00	0.7%
Dermatological	$1.48	151.6%	$0.02	($0.01)	1.0%
Diabetes	$1.56	188.7%	$0.05	$0.03	7.9%
Diabetic Supplies	$0.09	10.5%	$0.03	$0.01	4.0%
Endocrine and Metabolic Agents	$0.30	31.0%	$0.01	$0.01	1.7%
Gastrointestinal Agents	$1.03	106.1%	($0.01)	$0.02	1.1%
Hematological Agents	$0.01	1.2%	$0.01	$0.03	3.2%
HIV	$0.06	6.2%	($0.01)	$0.05	4.0%
Neurological Agents	$0.01	1.2%	$0.01	($0.05)	-3.5%
Ophthalmic Agents	$0.17	18.4%	$0.01	$0.03	3.7%
Other	$1.15	122.1%	$0.02	$0.00	2.5%
Pain	$0.20	20.6%	$0.00	$0.00	0.6%
Pain - Migraine	$0.05	6.5%	$0.07	$0.01	7.8%
Stimulants and Attention Disorders	$10.28	983.9%	$0.01	($0.03)	-1.7%
Substance Abuse	$0.00	0.2%	$0.04	($0.02)	2.3%
Transplant Agents	$0.04	3.7%	$0.01	$0.01	1.7%
Vaccines	$0.66	48.9%	($0.08)	($0.04)	-11.4%
Vitamins and Nutritionals	$0.12	12.6%	$0.01	$0.01	1.7%
Total Traditional	**$26.48**	**2668.7%**	**$0.01**	**($0.01)**	**0.3%**

Exhibit 7B
Mississippi Division of Medicaid
CHIP Program
Specialty Rx Trends by Therapeutic Class

Drug Class	PMPM Cost		Annualized CY 2021 to SFY 2024 Trend		
	CY 2021	SFY 2024	Utilization	Unit Cost	PMPM
Antiasthmatic and COPD Agents	$0.12	14.3%	$0.04	$0.04	8.2%
Anticonvulsants	$0.13	17.2%	$0.05	$0.06	11.3%
Anti-Inflammatory	$3.17	377.1%	$0.03	$0.04	7.1%
Atopic Dermatitis - Monoclonal Antibodies	$2.32	362.2%	$0.15	$0.04	19.6%
Cancer - Chemotherapy	$0.87	106.2%	$0.02	$0.06	8.1%
Cancer - Non-chemotherapy	$0.01	1.4%	$0.01	$0.04	5.0%
Cancer - Others	$0.00	0.5%	$0.01	$0.01	1.7%
Cardiovascular	$0.00	0.0%	$0.00	$0.00	0.0%
Chelating Agents	$0.06	6.2%	$0.02	($0.02)	0.0%
Contraceptives	$0.00	0.3%	$0.00	$0.04	4.0%
Cystic Fibrosis Agents	$2.52	301.1%	$0.02	$0.05	7.3%
Endocrine and Metabolic Agents	$0.64	83.3%	$0.08	$0.04	11.4%
Gastrointestinal Agents	$0.13	17.7%	$0.09	$0.03	12.5%
Growth Hormones	$1.48	175.7%	$0.03	$0.04	7.1%
Hematological Agents	$0.17	19.0%	$0.02	$0.02	4.4%
Hemophilia	$0.29	36.2%	$0.05	$0.03	8.7%
Hepatitis	$0.13	14.2%	$0.02	$0.00	2.0%
Hereditary Angioedema Agents	$0.05	5.5%	$0.03	$0.04	7.1%
Immune Serums	$0.09	10.9%	$0.02	$0.04	5.9%
Multiple Sclerosis	$0.51	54.5%	$0.01	$0.01	2.5%
Neurological Agents	$0.00	0.0%	$0.00	$0.00	0.0%
Other	$0.21	25.5%	$0.01	$0.07	8.7%
Total Specialty	**$12.93**	**1628.9%**	**$0.07**	**$0.03**	**9.7%**

Exhibit 8
Mississippi Division of Medicaid
Summary of CY 2021 CHIP Encounter Claims
CHIP Rate Cell

Member Months	554,885

	Total Costs	PMPM Costs
Inpatient Facility		
Medical	$2,668,041	$4.81
Surgical	$4,602,321	$8.29
Maternity / Deliveries	$301,800	$0.54
Psychiatric / Substance Abuse	$4,209,722	$7.59
Skilled Nursing Facility	$0	$0.00
Missing Data	$35,207	$0.06
Inpatient Behavioral Health Total	**$3,045,396**	**$5.49**
Inpatient Facility Total	**$11,817,090**	**$21.30**
Outpatient Facility		
Emergency Room	$7,195,504	$12.97
Urgent Care	$218	$0.00
Radiology / Pathology	$4,537,443	$8.18
Psychiatric / Alcohol & Drug Abuse	$448,602	$0.81
Pharmacy	$1,521,172	$2.74
Other	$11,255,570	$20.28
Missing Data	$133,116	$0.24
Outpatient Behavioral Health Total	**$427,976**	**$0.77**
Outpatient Facility Total	**$25,091,626**	**$45.22**
Physician		
IP Visits	$454,809	$0.82
IP Surgery	$399,636	$0.72
Office / Home Visits	$11,847,600	$21.35
Preventive Exams & Immunizations	$3,409,829	$6.15
Urgent Care Visits	$650,141	$1.17
ER Visits and Observation Care	$1,293,497	$2.33
OP Surgery	$2,852,333	$5.14
Physical Therapy	$1,230,364	$2.22
Psychiatric / Substance Abuse	$3,685,872	$6.64
Radiology / Pathology	$3,811,910	$6.87
Vision, Hearing, and Speech Exams	$1,632,489	$2.94
Other	$1,791,304	$3.23
Missing Data	$123,935	$0.22
Physician Behavioral Health Total	**$3,753,802**	**$6.77**
Physician Total	**$33,183,717**	**$59.80**
Pharmacy		
Pharmacy	$21,869,793	$39.41
Missing Data	$114,000	$0.21
Pharmacy Total	**$21,983,793**	**$39.62**
Dental		
Dental	$14,335,134	$25.83
Missing Data	$77,549	$0.14
Dental Total	**$14,412,684**	**$25.97**
Other		
Ambulance	$582,310	$1.05
Non-Emergency Transportation	$9,325	$0.02
DME	$1,015,512	$1.83
Glasses / Contacts	$730,152	$1.32
Other	$182,747	$0.33
Missing Data	$15,092	$0.03
Other Behavioral Health Total	**$65,042**	**$0.12**
Other Total	**$2,535,138**	**$4.57**
Total Behavioral Health	**$7,292,216**	**$13.14**
Grand Total	**$109,024,047**	**$196.48**

Exhibit 9
Mississippi Division of Medicaid
SFY 2024 CHIP Capitation Rate Development
Seasonal Virus Adjustment

	Children[1]		
Year	COVID-19	Flu/RSV	Total
CY 2018	$0.00	$4.68	$4.68
CY 2019	$0.00	$7.41	$7.41
CY 2021	$6.41	$2.45	$8.85
SFY 2024 Estimate[2]	$3.20	$6.05	$9.25
SFY 2024 Adjustment	-$3.20	$3.60	$0.40

[1] Children include the CHIP, Foster Care, MA Children, Quasi-CHIP, and MYPAC rate cells.

[2] The SFY 2024 estimate includes 50% of the observed CY 2021 COVID-19 costs and 100% of the average CY 2018 and CY 2019 historical flu/RSV costs.

Exhibit 10
Mississippi Division of Medicaid
SFY 2024 CHIP Capitation Rate Development
Enhanced Match Services

Rate Cell	Medical Portion of Capitation Rate	COVID-19 Vaccine Administration	Family Planning (Non-waiver)	Breast and Cervical Cancer	Indian Health Services	Home Health Services	Rehab Services	Private Duty Nursing
CHIP	$222.86	$0.95	$1.37	$0.00	$0.00	$0.00	$1.46	$0.00

Exhibit 11
Mississippi Division of Medicaid
SFY 2024 CHIP Capitation Rate Development
CHIP Expenditure Projection

Eligibility Category	*a* Projected SFY 2024 Exposures	*b* SFY 2024 Capitation Rates	*c = a * b* CHIP Estimated Cost	*d = c * 84.55%* Federal Estimated Cost[1]
All Children	512,655	$260.82	$133,708,696	$113,044,017

[1] For SFY 2024, EFMAP is calculated as the blend of six months using an EFMAP of 85.00% and six months using an EFMAP of 84.09%. These EFMAP projections include the phase-down of the additional federal match as described in the 2023 Consolidated Appropriations Act.

Exhibit 12
Mississippi Division of Medicaid
Insulin Price Reduction by Product

Product Name	Manufacturer	Price Reduction
APIDRA	SANOFI-AVENTIS U.S.	Reduced by 70%
APIDRA SOLOSTAR	SANOFI-AVENTIS U.S.	Reduced by 70%
HUMALOG	LILLY	Reduced by 70%
HUMALOG JUNIOR KWIKPEN	LILLY	Reduced by 70%
HUMALOG KWIKPEN	LILLY	Reduced by 70%
HUMALOG MIX 50/50	LILLY	Reduced by 70%
HUMALOG MIX 50/50 KWIKPEN	LILLY	Reduced by 70%
HUMALOG MIX 75/25	LILLY	Reduced by 70%
HUMALOG MIX 75/25 KWIKPEN	LILLY	Reduced by 70%
HUMULIN 70/30	LILLY	Reduced by 70%
HUMULIN 70/30 KWIKPEN	LILLY	Reduced by 70%
HUMULIN N	LILLY	Reduced by 70%
HUMULIN N KWIKPEN	LILLY	Reduced by 70%
HUMULIN R	LILLY	Reduced by 70%
INSULIN ASPART	NOVO NORDISK	Reduced to match branded price
INSULIN ASPART FLEXPEN	NOVO NORDISK	Reduced to match branded price
INSULIN ASPART PROTAMINE/	NOVO NORDISK	Reduced to match branded price
INSULIN LISPRO	LILLY	$25 / vial
LANTUS	SANOFI-AVENTIS U.S.	Reduced by 78%
LANTUS	NOVAPLUS/SANOFI-AVENTIS	Reduced by 78%
LANTUS SOLOSTAR	NOVAPLUS/SANOFI-AVENTIS	Reduced by 78%
LANTUS SOLOSTAR	SANOFI-AVENTIS U.S.	Reduced by 78%
LEVEMIR	NOVO NORDISK	$107.85 / vial
LEVEMIR FLEXPEN	NOVO NORDISK	$161.77 / Flexpen
LEVEMIR FLEXTOUCH	NOVO NORDISK	$161.77 / Flexpen
NOVOLIN 70/30	NOVO NORDISK	$48.20 / Vial
NOVOLIN 70/30 FLEXPEN	NOVO NORDISK	$91.09 / 5 pack of pens
NOVOLIN 70/30 FLEXPEN REL	NOVO NORDISK	$91.09 / 5 pack of pens
NOVOLIN 70/30 RELION	NOVO NORDISK	$48.20 / Vial
NOVOLIN N	NOVO NORDISK	$48.20 / Vial
NOVOLIN N FLEXPEN	NOVO NORDISK	$91.09 / 5 pack of pens
NOVOLIN N FLEXPEN RELION	NOVO NORDISK	$91.09 / 5 pack of pens
NOVOLIN N RELION	NOVO NORDISK	$48.20 / Vial
NOVOLIN R	NOVO NORDISK	$48.20 / Vial
NOVOLIN R FLEXPEN	NOVO NORDISK	$91.09 / 5 pack of pens
NOVOLIN R FLEXPEN RELION	NOVO NORDISK	$91.09 / 5 pack of pens
NOVOLIN R RELION	NOVO NORDISK	$48.20 / Vial
NOVOLOG	NOVO NORDISK	$72.34 / Vial
NOVOLOG FLEXPEN	NOVO NORDISK	$139.71 / 5pak of pens
NOVOLOG FLEXPEN RELION	NOVO NORDISK	$139.71 / 5pak of pens
NOVOLOG MIX 70/30	NOVO NORDISK	$72.34 / Vial
NOVOLOG MIX 70/30 PREFILL	NOVO NORDISK	$139.71 / 5pak of pens
NOVOLOG MIX 70/30 RELION	NOVO NORDISK	$72.34 / Vial
NOVOLOG RELION	NOVO NORDISK	$72.34 / Vial

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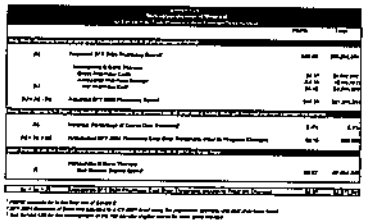

Exhibit 13D
Mississippi Division of Medicaid
SFY 2024 High Cost Pharmacy Risk Corridor Development - Gene Therapy Support

	Hemophilia B Gene Therapy	
(a)	Expected Number of Therapies	1
(b)	Net Pharmacy Cost for Gene Therapy[1]	$3,394,308
(c)	Applicable Inpatient Hospital Cost for Gene Therapy	$0
(d) = (b) + (c)	*Total Gene Therapy Cost*	$3,394,308
(e) = (d) / (a)	Total Cost per Therapy	$3,394,308
(f)	Average Prior Pharmacy Spend per Member[2]	$0
(g)	Pharmacy RC Threshold per Member	$500,000
(h) = max[(e) + (f) - (g), 0]	*RC Eligible Dollars per Member*	$2,894,308
(i) = (h) x (a)	*Total RC Eligible Dollars*	$2,894,308

[1] *Reconciles to Exhibit 13A item (b)*
[2] *CY 2021 average pharmacy spend trended forward to SFY 2024 for gene therapies with more than 10 potential patients*

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.

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 CHIP Members [42 CFR 438.8(a)] (referred to hereafter as MLR Report). A run-out period of 180 days is required for the final annual MLR report. For the 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. Premium Revenue

   A Contractor must report to the Division the total Premium Revenue received from the Division for each MLR Reporting Year. Premium Revenue includes, but is not limited to, all monies paid by the Division to the Contractor for providing benefits

and services as defined in the terms of the Contract and is inclusive of Capitation Payments, Capitation Premium Withhold amounts earned, Health Insurer Fee reimbursement, Risk Corridor adjustments, and any other Medicaid Managed Care Program Revenues. (Note: Other revenues may be inclusive of payments made for services such as high-cost drugs paid outside the capitation rate.)

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. <u>Reimbursement for Clinical Services Provided to Members</u>

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

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.

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

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

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

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

   Fraud Prevention Expenses are defined as expenses incurred <u>prior</u> 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 <u>subsequent</u> 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 be directly related to activities that improve healthcare quality and meet the following requirements:

    a. An activity that meets the requirements of 45 C.F.R. § 158.150(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;

b. The activity must be primarily designed to:

   i. 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;

ii. Accreditation fees directly related to quality of care activities;

iii. 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.

iv. 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.

v. 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.

vi. 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 may be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS (Public Health Service) Act and as approved by DOM;

(f) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(g) Coaching or education programs and health promotion activities designed to change Member behavior and conditions (for example, smoking or obesity); and,

(h) Health information technology to support these activities.

vii. 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.

Note: DOM has adopted the definitions and guidelines provided in the Patient Protection and Affordable Care Act, 45 CFR Parts 144, 147, 153, 155, 156, and 158 as recorded in the Federal Register, Vol. 87, No. 88, issued on May 6, 2022. Qualifying direct quality improvement activity (QIA) expense is limited to the QIA portion of salaries and benefits for employees directly performing QIA functions for inclusion in the MLR calculation. Expenses for items such as office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, wall art), human resources, salaries of counsel and executives, equipment, computer and telephone usage, travel and entertainment, company parties and retreats, IT infrastructure and systems, and software licenses do not qualify as direct QIA expense. Please reference the guidance provided in PPACA regulation, as well as the remainder of this section when determining reportable QIA expense.

D. <u>Activities Related to External Quality Review</u>

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. <u>Non-Claims Costs</u>

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. 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 ratá 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 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.

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 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 D 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. If the Contractor's experience in "non-credible, the Contractor is presumed to meet or exceed the MLR calculation standards.

f. Aggregation of Data: Contractor will aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

2. Rebating Capitation Payments if the 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 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.