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

(Molina Healthcare of Mississippi, Inc.)

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

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

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

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

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

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

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

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

S. APPROVAL

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

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

T. REPRESENTATION REGARDING GRATUITIES

The bidder, offeror, or Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations.*

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

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

III. Section 5.J.2.a, EMERGENCY ADMISSION REVIEWS, is amended to read as follows: The Contractor shall have the capability and established procedures to receive Emergency Admission Reviews for post-admissions that are not planned or elective and conduct prior authorizations when the Member has not been discharged. The Contractor shall ensure determinations for Emergency Admission Reviews are completed ninety-eight percent (98%) of the time within one (1) business day of receipt.

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

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

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

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

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

The Contractor shall have the capability and established procedures to receive Continued Stay Reviews requests for additional inpatient days of care for admissions previously certified and conduct prior authorizations on or before the next review point (i.e. the last

certified day). The Contractor shall ensure determinations for Continued Stay Reviews are completed ninety-eight percent (98%) of the time within one (1) business day of receipt when Members remain hospitalized and within one (1) business day of receipt when Members have been discharged.

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

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

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

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

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

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

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

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

G. Medical Loss Ratio

The Contractor shall provide quarterly and annual Medical Loss Ratio (MLR) reports as specified by the Division and in accordance with Exhibit C, Medical Loss Ratio (MLR) Calculation Methodology, of this Contract. The Division reserves the right to make such reports available to the public in their entirety. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-seven and one-half percent (87.5%), the Contractor shall refund the Division the difference no later than the tenth (10th) business day of May following the end of the MLR Reporting Year. Any unpaid balances after the tenth (10th) business day of May shall be subject to interest of ten percent (10%) per annum.

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

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

13.1.9., LOSS OF PROGRAM AUTHORITY

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

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

J. Mississippi Medicaid Access to Physician Services

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

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

K. Autism Spectrum Disorder

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

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

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

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

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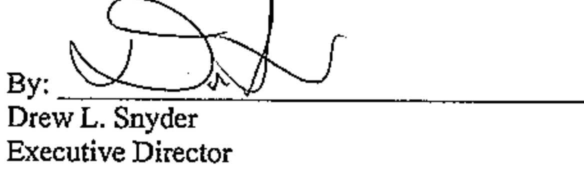
IN WITNESS WHEREOF, the parties have executed this Amendment Number Ten by their duly authorized representatives as follows:

Mississippi Division of Medicaid



By: ______________________
Drew L. Snyder
Executive Director

Date: May 11, 2021

Molina Healthcare of Mississippi, Inc.

By: ______________________
Bridget Galatas
President & Chief Executive Officer

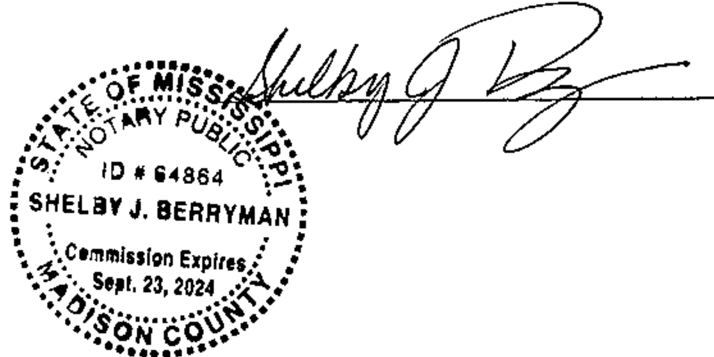
Date: May 07, 2021

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 May, 2021.

NOTARY PUBLIC



My Commission Expires:

Sept 23, 2024

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, **Bridget Galatas,** in her respective capacity as the **President and Chief Executive Officer of Molina Healthcare 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 7th day of May, 2021.

NOTARY PUBLIC

My Commission Expires:

June 16, 2023