AMENDMENT NUMBER THIRTEEN
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 THIRTEEN 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") and collectively hereinafter referenced as the "Parties."

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, the 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, the Parties desire to extend the Contract for an additional year pursuant to Miss. Code Ann. § 43-13-117(H)(12);

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, #9, #10, #11, and #12; 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.A, GENERAL PROVISIONS – Term, is amended to read as follows:

A. Term

The Contract period begins July 1, 2017 and shall terminate on June 30, 2023.

II. Section 7.E, PROVIDER NETWORK – Provider Credentialing and Qualifications, is amended to read as follows:

E. Provider Credentialing and Qualifications

Pursuant to *Miss. Code Ann. §43-13-117(H)(6),* effective July 1, 2022, no health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program, or coordinated care program implemented by the Division, and under this section shall require its providers to be credentialed by the organization in order to receive reimbursement from the organization, but those organizations shall recognize the credentialing or screening of the providers by the Division.

Therefore, effective July 1, 2022, Contractor will be provided with a provider master file from the Division. No Contractor shall require its providers to be separately credentialed by the Contractor in order to receive reimbursement from the Contractor.

The Contractor must have signed contracts or participation agreements with the providers, in accordance with 42 C.F.R. § 438.214 and Mississippi Insurance Department Regulation 98-1. The Contractor must utilize a universal contracting process for MississippiCAN Providers as established or approved by the Division. Provider must be contained within the provider master file as provided by DOM before final execution of the contract with the Provider.

The Contractor's policies and procedures must meet the requirements within 42 C.F.R.§ 438.12 and must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

The Contractor must verify that all Network Providers and any Out-of-network Providers to whom Members may be referred are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening

and enrollment requirements of 42 C.F.R. Part 455, subparts B and E and have in effect appropriate policies of malpractice insurance as may be required by the Contractor and the Division. This provision does not require the Network Provider to render services to fee-for-service beneficiaries.

All Contractor Network Providers must also be enrolled in the Mississippi Medicaid program using the same National Provider Identifier (NPI) numbers and Mississippi Medicaid Provider Numbers with active enrollment segments. Additionally, all Contractor Network Providers must be enrolled as Group or Individual providers consistent with enrollment with the Division. Contractor must ensure that all contracted nurse practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting at PCPs. The Contractor may execute Network Provider agreements pending the outcome of the process in § 438.602 (b)(1), but must terminate a Network Provider immediately upon notification from the State that the Network Provider cannot be enrolled, or upon the expiration of one hundred and twenty (120) days after the start date of the provider agreement and notify affected enrollees.

In contracting with Providers, Contractor will abide by all applicable Federal regulations, including 42 C.F.R. 438.608(b).

Contractor's Medical Director shall participate as a member of the Division's credentialing committee.

Contractor shall verify inclusion of Providers in the master file as provided by DOM. Pursuant to 42 C.F.R. 455.410, the Division will conduct all Provider screenings to include, but not be limited to the following databases: HHS-OIG's List of Excluded Individuals and Entities (LEIE), System of Award Management (SAM), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, National Practitioner Data Bank (NPDB), Health Integrity and Protection Databank (HIPDB), and any State listings of excluded Providers.

Practitioner shall be allowed to review the information utilized in the decision making process related to the practitioner's credentialing application.

The Division shall notify a practitioner of any information obtained during the credentialing process that varies substantially from the information provided to the Division by the practitioner. The Division shall notify a practitioner within five (5) business days of any missing or invalid information that would impede completion of credentialing and/or contracting.

In the event the Contractor decides to deny a provider's a request to contract, the Contractor shall notify the Provider and the Division within ten (10) calendar days of the Provider request to contract either for program integrity-related reasons, due to limitations placed on the Provider's ability to

participate for program integrity-related reasons, or the Contractor's decisions not to allow a Provider to participate in the network. Contractor shall notify the Provider within five (5) business days of Contractor's denial of participation in the network.

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

The Contractor must submit reports in accordance with Section 11.E, Provider Services Reports, of this Contract.

III. Section 10, QUALITY MANAGEMENT, is amended to add the following:

V. Quality Withhold Measurements and Targets:

CCO MSCAN SFY 2023 Incentive/Withhold Targets

Quality Measure	Sub Measure	Target
** Well Child Visits - First 30 Months of Life (W30)	*children 15 months of age with 6+ visits*	55.79%
	children 30 months of age with 2+ visits	NA
Immunizations for Adolescents (IMA)	*Combination 2*	22.52%
Anti-Depressant Management	*Effective Acute Phase Treatment*	44.59%
Timeliness of Prenatal Care		94.92%
Comprehensive Diabetes Care - CDC (SPD)	*HbA1c Testing*	87.85%
Adults & Children: Asthma ages 5-64	*(AMR) Total*	72.89%
Adults: Pharmacotherapy Management of COPD Exacerbation (PCF)	*Systemic Corticosteroid*	47.70%
COVID-19 vaccination rates		40% of membership age 12 and older
QIPP PPHR A/E Ratio		2% improvement over Baseline

IV. Section 11.E., REPORTING REQUIREMENTS – Provider Services Reports, is hereby amended to read as follows:

E. Provider Services Reports

The Contractor shall submit a quarterly report providing information on general Provider services operations including, but not limited to, Provider

enrollment, Provider services call center, staff training, and Complaints, Grievances, and Appeals.

V. Section 13.A.9., CAPITATION RATES, is hereby amended to add the following:

The table below includes Capitation Rates of this Contract, which are the capitation rates per member per month (PMPM) varying by region and Rate Cell. Each Contractor will be paid based on the distribution of Members they have in each Rate Cell. The Non-Newborn SSI/Disabled, MA Adult, MA Children and Quasi-CHIP Rate Cells will be risk adjusted. These four Rate Cells have a Risk Adjustment factor, calculated on a prospective basis using CDPS+RX, applied to each rate re-calculated based on each Contractor's actual risk scores. The Foster Care Rate Cell will also be risk adjusted on a concurrent basis using a members' eligibility for either state or federal financial assistance to assign a risk score.

The table below establishes the Coordinated Care Organization Capitation Rates per member per month (PMPM) for MississippiCAN. These rates are effective for the following MississippiCAN Rate Cells: Non-Newborn SSI/Disabled; Foster Care; Breast and Cervical Cancer; SSI/Disabled Newborn; MA Adults; Pregnant Women; and Non-SSI Newborns. Additionally, Capitation Rates are included for MA Children and Quasi-CHIP Children, and Mississippi Youth Programs Around the Clock (MYPAC) rate cells. Capitation rates are for the period of State Fiscal Year 2023 (July 1, 2022 through June 30, 2023).

Molina Healthcare of Mississippi, Inc. **MississippiCAN Capitation Rates** Capitation Rates PMPM (excluding Risk Scores) Effective July 1, 2022 – June 30, 2023			
Rate Cell	**North**	**Central**	**South**
SSI-Disabled	**$1,080.78**	**$1,243.14**	**$1,233.65**
Breast/Cervical Cancer	**$3,482.68**	**$4,005.85**	**$3,975.30**
MA Adults	**$498.79**	**$549.98**	**$532.04**
Pregnant Women	**$1,086.96**	**$1,198.53**	**$1,159.42**
SSI-Disabled Newborn	**$8,591.80**	**$8,924.61**	**$8,731.93**
Non-SSI Newborns 0-2 Months	**$1,985.84**	**$2,062.77**	**$2,018.23**
Non-SSI Newborns 3-12 Months	**$274.59**	**$285.22**	**$279.07**
Foster Care	**$656.73**	**$682.17**	**$667.45**
MYPAC	**$4,058.49**	**$4,215.70**	**$4,124.69**
MA Children	**$217.43**	**$225.86**	**$220.98**
Quasi-CHIP	**$219.75**	**$228.26**	**$223.33**

*Capitation rate per April 20, 2022 Actuarial Report attached as Exhibit 1 to this Amendment.

The Contractor is not allowed to affect the assignment of risk scores through any post-billing claims review process for the assignment of additional diagnosis codes. Diagnosis codes may only be recorded by the Provider at the time of the creation of the medical record and may not be retroactively adjusted except to correct errors.

VI. Section 13.A., CAPITATION PAYMENTS, is hereby amended to add the following:

10. Risk Corridor – State Fiscal Year (SFY) 2023

a. The Division will implement a symmetrical risk corridor for the timeframe of July 1, 2022 through June 30, 2023 ("SFY 2023") to address the uncertainty of medical costs given the COVID-19 pandemic. The risk corridor was developed in accordance with generally accepted accounting principles and practices.

The Contractor capitation rates reflect a target medical loss ratio (MLR) which measures projected medical service costs as a percentage of the total capitation rates paid to the Contractor. The 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 2023 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 the purposes of the SFY 2023 Risk Corridor, a different definition of MLR will be used than the Federal MLR definition.

Exhibit 16 of the April 20, 2022 rate certification letter, "Report05 – SFY 2023 Preliminary MississippiCAN Rate Calculation and Certification," illustrates the calculation of the target MLR for each CCO. The final target MLR will vary for each CCO and will depend on several currently unknown

factors, including the final risk scores for each risk adjusted rate cell, the amount of the quality withhold returned to each CCO, and the results of the final settlements for MHAP and MAPS. Exhibit 16 does not reflect the actual target MLR to be used for any CCO, but is shown for illustrative purposes. Moreover, Exhibit 16 does not reflect regional variations in capitation rates and risk scores (for applicable rate cells), which will be considered in the final risk corridor calculation. More detailed templates will be provided to the CCOs demonstrating the actual calculation to be used when developing risk corridor settlements.

The Risk Corridor will be implemented using the following provisions:

1) Actual and Target MLRs will be calculated for Contractor based on actual enrollment mix.
2) The numerator of the Contractor's actual MLR will include state plan covered services incurred during the period of SFY 2023 with payments made to providers as defined in Exhibit C of the CCO Contract, including fee-for-service payments, subcapitation payments, and settlement payments. Non-covered services will be removed from the numerator
3) Payments and revenue related to MHAP and MAPS will be included in the numerator and denominator of the Contractor's actual MLR.
4) Adjustments to revenue and claims resulting from the MLR audit will be incorporated into the calculation of each Contractor's actual MLR.
4) The 87.5% minimum MLR provision in Section 13.G of the Contract will apply after the risk corridor settlement calculation.

The initial risk corridor calculation and settlement will occur using the SFY 2023 values included in the annual MLR report submitted from the Contractor to the Division with six (6) months of runout. A final calculation of payments or recoupments as a result of the risk corridor will occur once the MLR audit has been completed, typically 12 to 18 months after the close of the state fiscal year.

VII. Section 13.B., FINANCIAL REQUIREMENTS – Mississippi Hospital Access Program, is hereby amended to replace the third paragraph of that subsection with the following:

B. Mississippi Hospital Access Program

The Contractor shall ensure all MHAP payments are distributed for the purpose of protecting patient access to hospital care at all in-state hospitals of all classes.

Contractor shall ensure all MHAP payments are distributed pursuant to the requirements and conditions as outlined in Miss. Code Ann. §43-13-117, *et. seq*

(1972, as amended) for the purpose of protecting patient access to hospital care at the following out-of-state hospitals that are:

1) authorized by federal law to submit intergovernmental transfers (IGT's) to the State of Mississippi and classified as a Level I trauma center located in a county contiguous to the state line at least at a level of access available as of November 30, 2015; and
2) authorized by the Mississippi State Legislature to include a border city university-affiliated pediatric teaching hospital located within a city bordering the eastern bank of the Mississippi River and the State of Mississippi that submits to the Division a copy of a current and effective affiliation agreement with an accredited university and other documentation establishing that the hospital is university-affiliated, is licensed and designated as a pediatric hospital or pediatric primary hospital with its home state, maintains at least five (5) different pediatric specialty training programs, and maintains at least one hundred (100) operated beds dedicated exclusively for the treatment of patients under the age of twenty-one (21) years.

VIII. Section 13, FINANCIAL REQUIREMENTS, is hereby amended to add the following:

L. **Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Directed Payments**

The TREAT ambulance directed payment arrangement will reimburse emergency ambulance services providers based on actual emergency ambulance services provided to members in the MississippiCAN program. The payment arrangement is intended to improve access to care by providing funding needed to maintain adequate emergency services and/or attracting new ambulance service providers to serve the MississippiCAN membership. The payment methodology, which is included in the preprint, must be approved by CMS annually and is pursuant to 42 C.F.R. § 438.6(c).

Contractor will receive payments for TREAT outside of the monthly capitation payments. Within five (5) business days of receipt of TREAT payments, the Contractor shall distribute the TREAT funds to emergency service ambulance providers with no amount withheld for administrative cost.

Contractor will be required to report to the Division, in accordance with the Division's reporting requirements, all payments made to TREAT providers.

IX. Section 16.E., DEFAULT AND TERMINATION – Liquidated Damages, Table 11, is hereby amended as follows:

"Provider Credentialing" is removed and replaced with the following:

Failed Deliverable	Damages
Provider Contracting	If the Division determines that the Contractor has not completed upload of Providers' information into its claims processing system within thirty (30) calendar days, or failure to notify the Provider and the Division within ten (10) calendar days of the Contractor's denial of a Provider request to contract, the Division may impose liquidated damages of up to five thousand dollars ($5,000.00) per violation.

"Premium" is removed and replaced with the following:

Failed Deliverable	Damages
Cost Sharing	If Contractor imposes premiums or charges on Members that are in excess of those permitted, the Division may assess liquidated damages of up to twenty- five thousand dollars ($25,000.00) or double the amount of the excess charges, whichever is greater, per claim violation. The Division will also deduct the amount of the overcharge from assessed liquidated damages and return it to the affected Member.

All other Failed Deliverables and Damages within Table 11 of Section 16.E., DEFAULT AND TERMINATION – Liquidated Damages remain unchanged through this Amendment 13 and in full force and effect as agreed to by the Parties within Amendment #4, Attachment A.

X. Section 18, CLAIMS MANAGEMENT, is hereby amended to add the following:

D. Ventilators

The Contractor is prohibited from setting a maximum dollar amount of reimbursement for noninvasive ventilators or ventilation treatments properly ordered and used in an appropriate setting. The Contractor must reimburse durable medical equipment suppliers for home use of noninvasive and invasive ventilators on a continuous monthly payment basis for the duration of the Member's medical need throughout the Member's valid prescription period.

XI. 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 Thirteen.

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

Mississippi Division of Medicaid

By: _____
Drew L. Snyder
Executive Director

Date: June 3, 2022

Molina Healthcare of Mississippi, Inc.

By: _____
Bridget Galatas
President and Chief Executive Officer

Date: June 2, 2022

STATE OF MISSISSIPPI
COUNTY OF Lincoln

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 Thirteen** 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 3rd day of June, A.D., 2022.

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 Hinds

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **Bridget Galatas**, in his 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 Thirteen** 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 2nd day of June, A.D., 2022.

STATE OF MISSISSIPPI NORMA L. DEMPSEY NOTARY PUBLIC ID No. 89181 Commission Expires June 16, 2023 HINDS COUNTY

NOTARY PUBLIC

My Commission Expires:
June 16, 2023