AMENDMENT NUMBER FOURTEEN
TO THE CONTRACT BETWEEN
THE DIVISION OF MEDICAID
IN THE OFFICE OF THE GOVERNOR
AND
MAGNOLIA HEALTH PLAN, INC.
A CARE COORDINATION ORGANIZATION (CCO)

(Magnolia Health Plan, Inc.)

THIS AMENDMENT NUMBER FOURTEEN 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 **Magnolia Health Plan, 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, 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 is engaged in the business of providing comprehensive services as outlined 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 extended the Contract for an additional year pursuant to Miss. Code Ann. § 43-13-117(H)(12) through Amendment 13 as approved by the Public Procurement Review Board (PPRB);

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; and

WHEREAS, the parties have previously modified the Contract in Amendments #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13.

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 5.A., COVERED SERVICES AND BENEFITS – Covered Services is hereby amended to read as follows:

A. Covered Services

The Contractor shall provide all Medically Necessary covered services allowed under the MississippiCAN Program. The contractor shall ensure that all covered services are sufficient in an amount, duration, and scope to reasonably achieve its purpose as set forth in 42 C.F.R. § 440.230 and that no incentive is provided, monetary or otherwise, to Providers for withholding Medically Necessary covered services from a Member. The Contractor shall make available accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this Contract.

The Contractor shall comply with Medicaid NCCI guidelines. The Contractor shall have policies, approved by the Division, that address manually priced claims.

Contractor must have policies and procedures in place to deal with states of emergency. The Division may lift service limits for beneficiaries during states of emergency, and Contractor must provide, at minimum, coverage for the same level of services being covered by the Division during the state of emergency.

The Division will annually review the cost and utilization of high-cost medications for consideration of either exclusion from coverage as a covered benefit or exclusion from the capitation rate. Any high-cost medications excluded from coverage as a covered benefit shall not be reimbursed. Any high-cost medications excluded from payment in the capitation rate based on this review will be reimbursed outside of the monthly capitation payment.

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

The tables below include 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 tables below establish the CCO Capitation Rates per member per month (PMPM) for MississippiCAN. These rates are effective for the following 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 periods of State Fiscal Year 2022 (July 1, 2021 through June 30, 2022) and State Fiscal Year 2023 (July 1, 2022 through June 30, 2023) respectively.

These rates do exclude MHAP FSA; however, the MHAP FSA will be paid separately monthly as a financial transaction. Rates are prior to the application of a 1.00 percent Quality Withhold. These rates exclude MHAP QIPP, MAPS, TREAT and HIF (as applicable).

Magnolia Health Plan, Inc.
MississippiCAN Capitation Rates State Fiscal Year (SFY 22)
Capitation Rates PMPM (excluding Risk Scores)
Effective July 1, 2021 – June 30, 2022

Rate Cell	North	Central	South
Non- Newborn SSI-Disabled	$1,083.35	$1,270.34	$1,272.75
Breast/Cervical Cancer	$3,436.96	$4,030.20	$4,037.86
MA Adults	$505.81	$561.60	$539.60
Pregnant Women	$1,104.87	$1,226.72	$1,178.68
SSI-Disabled Newborn	$8,515.72	$8,916.67	$8,690.05
Non-SSI Newborns 0-2 Months	$2,037.47	$2,133.40	$2,079.18
Non-SSI Newborns 3-12 Months	$279.50	$292.66	$285.22
Foster Care	$667.14	$698.55	$680.79
MYPAC	$4,131.31	$4,325.83	$4,215.88
MA Children	$223.86	$234.40	$228.44
Quasi-CHIP	$226.57	$237.24	$231.21

*Capitation rate per August 9, 2022 Actuarial Report attached as Exhibit 1 to this Amendment.
Rates are prior to the application of a 1.00% quality withhold.
Rates exclude MHAP and MAPS.

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.

Magnolia Health Plan, Inc. MississippiCAN Capitation Rates State Fiscal Year (SFY 23) Capitation Rates PMPM (excluding Risk Scores) Effective July 1, 2022 – June 30, 2023			
Rate Cell	**North**	**Central**	**South**
Non- Newborn SSI-Disabled	**$1,099.90**	**$1,265.12**	**$1,255.47**
Breast/Cervical Cancer	**$3,538.01**	**$4,069.49**	**$4,038.45**
MA Adults	**$513.30**	**$565.44**	**$548.06**
Pregnant Women	**$1,108.63**	**$1,221.25**	**$1,183.71**
SSI-Disabled Newborn	**$8,693.79**	**$9,030.55**	**$8,835.59**
Non-SSI Newborns 0-2 Months	**$2,004.86**	**$2,082.52**	**$2,037.56**
Non-SSI Newborns 3-12 Months	**$280.84**	**$291.72**	**$285.42**
Foster Care	**$666.15**	**$691.96**	**$677.02**
MYPAC	**$4,067.17**	**$4,224.72**	**$4,133.51**
MA Children	**$221.82**	**$230.41**	**$225.43**
Quasi-CHIP	**$224.23**	**$232.92**	**$227.89**

*Capitation rate per September 14, 2022 Actuarial Report attached as Exhibit 2 to this Amendment.

Rate changes exclude MHAP, MAPS, TREAT, and the 1.0% quality withhold.

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.

III. Section 11.S.3, REPORTING REQUIREMENTS –Member Encounter Data: Member Encounter Data Provision, Submissions, and Processing Requirements is hereby amended to read as follows:

3. Member Encounter Data Provision, Submissions, and Processing Requirements

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

relevant to the adjudication and payment of claims in sufficient detail in order to support comprehensive financial reporting and utilization analysis.

The level of detail in the Member Encounter Data provided by the Contractor to the Division shall be equivalent to the level of detail associated with that Member Encounter Data when it is submitted to and adjudicated by Contractor for claims payment. The Contractor must collect and maintain sufficient Member Encounter Data to identify the provider who delivers any item(s) or service(s) to Members. The Provider's National Provider Identifier (NPI) shall be used when submitting required Member Encounter Data. Member Encounter Data elements must include all of the data the Division is required to report to CMS under 42 C.F.R. § 438.818 including but not limited to:

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

The Contractor must submit complete and accurate Member Encounter Data that includes:

a. all Member Encounter Data,
b. Member Encounter Data adjustments,
c. encounters reflecting a zero-dollar amount ($0.00),
d. encounters reflecting claim voids,
e. encounter claims reflecting denied claims, and
f. encounters in which the Contractor has a capitation arrangement with a provider.

The Member Encounter Data files shall contain settled claims and claim adjustments processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the Contractor has a capitation arrangement. These settle claims and claims adjustments include, but are not limited to: (a) adjustments necessitated by administrative payments or recoupments, (b) program integrity recoupments, (c) lump sum payments, and (d) payment errors. Submissions shall be comprised of encounter records or adjustments to previously submitted records, which the Contractor has received and processed from provider encounter or claim records of all contracted services rendered to the Member in the current or preceding months.

For pharmacy encounter claims, the Contractor shall submit complete and accurate Member Encounter Data processed by the Contractor's Subcontractor within fifteen (15) calendar days following the date of adjudication.

Within two (2) business days of the end of a payment cycle the Contractor shall generate Member Encounter Data files for that payment cycle from its claims management system(s) and/or other sources. If the Contractor has more than one (1) payment cycle within the same calendar week, the Member Encounter Data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week. In no event, may Member Encounter Data be submitted by the Contractor or Subcontracts more than 30 calendar days after the date of adjudication.

The Contractor shall submit Member Encounter Data according to HIPAA X12 transaction standards and formats as defined by the Division, including those referenced in the companion Guide(s), complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All Member Encounter Data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates defined in Section 16.E of this Contract will be rejected and returned to the Contractor for immediate correction. When the Division or its Agent rejects a file of encounter claims, the rejected files must be resubmitted with all of the required data elements in the correct format by the Contractor within thirty (30) calendar days from the date the Agent rejected the file. The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance with these requirements.

The Contractor shall be able to receive, maintain, and utilize data extracts and data files from the Division and its Contractors. Based on the data extracts and data files received from the Division, the Contractor shall correct and resubmit rejected Encounter Records as an adjustment within the time frame referenced above.

The Division provides a listing of encounter claim edits to the Contractor, which includes a comprehensive listing of edits such as X12, FFS, and other agency edits, to ensure quality encounter data. Corrections and resubmissions must pass all edits before they are accepted for processing in electronic form in the MMIS system by the Division's Agent. Only accepted encounters are used for evaluation of rate development, risk adjustment, and quality assurance.

Member Encounter Records that deny due to the Division's Agent's edits are returned to the Contractor and the Contractor must make the requested corrections, if possible.

The Contractor must make an adjustment to encounter claims when the Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed. If the Division or its Agent discovers errors or a conflict with a previously adjudicated encounter claim the Contractor shall be required to adjust or void the encounter claim within thirty (30) calendar days of notification by the Division. The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance with these requirements.

Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the Contractor's applicable reimbursement methodology for that service.

An encounter claim rejection occurs before the claim is processed in the MMIS system and most often results from incorrect data. The Contractor shall correct and resubmit rejected Encounter Records within the time frame referenced above. Corrections and resubmissions must pass all edits before they are accepted for processing in electronic form in the MMIS system by the Division's Agent.

The Contractor shall ensure that the payment information on the Subcontractors' Member Encounter Data reflect the date and the amount paid to the provider by the Subcontractor. The Claim Received Date shall reflect the Subcontractor received the claim from the Provider. This Claim Received Date shall not reflect the date that the Contractor received the encounter claim from the Subcontractor.

Failure of Subcontractors to submit Member Encounter Data timely shall not excuse the Contractor of noncompliance with this requirement, and the Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance.

IV. EXHIBIT C: MEDICAL LOSS RATIO (MLR) REQUIREMENTS is hereby amended and replaced with "EXHIBIT C: MEDICAL LOSS RATIO (MLR) REQUIREMENTS" as attached and incorporated herein by reference to this Amendment 14.

V. 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 Fourteen.

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

Mississippi Division of Medicaid

By: _____
Drew L. Snyder
Executive Director

Date: 10/28/22

Magnolia Health Plan, Inc.

By: _____
Aaron Sisk
President & Chief Executive Officer

Date: 10/13/2022

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 Fourteen** 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 28th day of October, A.D., 2022.

NOTARY PUBLIC

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

My Commission Expires:
September 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, **Aaron Sisk**, in his respective capacity as the **President and Chief Executive Officer of Magnolia Health Plan, 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 Fourteen** 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 13th day of October, A.D., 2022.

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 291709 ANGELA C. BATES Commission Expires June 29, 2025 HINDS COUNTY

NOTARY PUBLIC

My Commission Expires:
June 29, 2025