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

(UnitedHealthcare of Mississippi, Inc.)

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

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

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

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

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

WHEREAS, the parties have previously modified the Contract in Amendments #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11; 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, GENERAL PROVISIONS, is amended to add the following:

U. Contractor Agreements Outside of This Contract
The Division enters into this Contract with the Contractor only. Any responsibilities, warranties, duties, and/or obligations borne by the Contractor

through any contracts, agreements, affiliations, or other relationships outside of this Contract are not transferrable and/or applicable to the Division without express written agreement and approval by the Division.

II. Section 2.A, DEFINITIONS, is amended to add the following:

Rework: Work performed by the Division and/or its Agent to identify deficiencies or errors associated with a deliverable, including but not limited to any root cause analysis and/or effort to identify the task(s) to be re-performed, as well as any other work performed by the Division and/or its Agent to correct any deficiencies or errors associated with a deliverable. The Division reserves the right to offset Contractor payments in the amount commensurate with the costs incurred by the Division for any rework.

III. Section 5.J., PRIOR AUTHORIZATIONS, Table 4, as well as paragraphs 2 and 4 of Subsection 6 of Section 5.J are amended to read as follows:

Table 4: Notification of Review Outcomes for Inpatient Medical/Surgical/Behavioral Health Services

Review Type	Contractor Action	Time Standard
Emergency Admission Reviews	Verbal and Written Approval to Provider	Within 24 hours from review determination
Non-Emergency Admission Reviews Weekend and Holiday Admission Reviews Continued Stay Reviews	Written Approval to Provider	Within one (1) business day from review determination
	Verbal Denial to Provider	Within 24 hours from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Member/ Parent/Representative	Within one (1) business day from review determination
Retrospective Inpatient Hospital Reviews	Written Approval to Provider	Within three (3) business days from review determination

Review Type	Contractor Action	Time Standard
Retroactive Eligibility Reviews	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Member/ Parent/Representative	Within three (3) business days from review determination

6. Time Frames for Non-Inpatient Hospital Medical Services

Contractor must make standard authorization decisions and provide notice ninety-eight percent (98%) of the time within three (3) calendar days and/or two (2) business days per Minimum Standards for Utilization Review Agents issued by the Mississippi State Department of Health (MSDH) following receipt of the request for services. If Contractor requires additional medical information in order to make a decision, Contractor will notify the requesting provider of additional medical information needed and Contractor must allow three (3) calendar days and/or two (2) business days for the requesting provider to submit the medical information. If Contractor does not receive the additional medical information, Contractor shall make a second attempt to notify the requestor of the additional medical information needed and Contractor must allow one (1) business day or three (3) calendar days for the requestor to submit medical information to Contractor.

The Contractor must expedite authorization for services when the Provider indicates or the Contractor determines that following the standard authorization decision time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. The Contractor must provide decision notice no later than twenty-four (24) hours after receipt of the expedited authorization request within ninety-eight percent (98%) of the time. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the Member, or the Provider to Contractor, or if Contractor requests an extension from the Division. The extension request to the Division applies only after Contractor has received all necessary medical information to render a decision and Contractor requires additional calendar days to make a decision. The extension request must justify to the Division a need for additional information and explain how the extension is in the Member's best interest. Any such request is subject to Division approval. The Division will evaluate Contractor's extension request and notify Contractor of decision within three (3) calendar days and/or two (2) business days of receiving Contractor's request. The Contractor must justify to the Division

a need for additional information and how the extension is in the Member's best interest.

IV. Section 6.A.5., MEMBER SERVICES – Member Services Call Center, is amended to add the following:

The Contractor shall maintain a monthly service level of answering no less than 85 percent (85%) of all calls by representatives within the first 60 seconds of their delivery to the queuing system. Initial call resolution representatives will handle no less than 80 percent of the calls to completion during the initial contact with the representative. A call is considered resolved during the initial contact if it does not require a return call by a customer service representative.

V. Section 7.H.1., PROVIDER NETWORK – Provider Services Call Center is amended to add the following:

The Contractor shall maintain a monthly service level of answering no less than 85 percent (85%) of all calls by representatives within the first 60 seconds of their delivery to the queuing system. Initial call resolution representatives will handle no less than 80 percent of the calls to completion during the initial contact with the representative. A call is considered resolved during the initial contact if it does not require a return call by a customer service representative.

VI. Section 7.I., PROVIDER NETWORK – Provider Complaint, Grievance, Appeal and State Administrative Hearing Process. Paragraph 3 of Section 7.I. is amended to read as follows:

The Division is the state agency that administers the Medicaid and CHIP healthcare programs. This state agency is responsible for managed care contract management and oversight and has the right to interject or intercede on the Provider's behalf to expedite or reconcile differences between parties while remaining neutral in this process. This intercession does not affect administrative proceedings, and does not negate or interfere with the Contract reference stating that the Provider must exhaust all Contractor level Appeal procedures prior to requesting a State Administrative Hearing with the Division. The Division shall have the right to intercede on a Provider's behalf whenever there is an indication from the Provider, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately, as well as other issues, including but not limited to, enrollment, credentialing, payments, and terminations. Failure to resolve the issues within the timeframe specified by the Division or as otherwise requested through the Corrective Action Plan may result in liquidated damages or other available remedies in accordance with Section 16, Default and Termination, of this Contract.

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

U. Quality Withhold

The Division withholds one-percent (1%) of the monthly Capitation Payment as an incentive to promote a core set of quality and health outcomes as determined by the Division. Each year, the Division will establish quality withhold measures and targets, with each measure being assigned a percentage of the withhold amount. For each measure, the Contractor must meet or exceed the established target to earn back the percentage of the withhold associated with that measure. The Contractor can only earn back the entirety of the withhold by meeting targets for all withhold measures.

If Contractor does not have sufficient data to consider its HEDIS scores credible, the Division will not hold the Contractor liable for not meeting the measurement. In this case, the portion of the incentive withheld related to that measurement will be returned to the Contractor.

Withhold measures will be revised on a yearly basis. HEDIS-associated measures will be measured on a calendar year period. Non-HEDIS-associated measures may be measured on a calendar year or the Mississippi state fiscal year period, at the discretion of the Division.

The withhold amount will correlate with state fiscal year capitation rates and will be withheld on a state fiscal year basis.

The reporting timeframes each year are as follows:

1. January 1 – December 31 – Preliminary report due by July 15 after the close of the state fiscal year.
2. January 1 – December 31 – Final rates reported by January 15 after the close of the state fiscal year.

Incentive payments earned back by the Contractor will be paid to the Contractor by the Division within thirty (30) calendar days after each reporting period deadline. The payment will equate to fifty percent (50%) of the total amount of incentive earned for the reporting date.

V. Quality Withhold Measurements and Targets:

CCO MSCAN SFY 2022 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*	19.05%
Anti-Depressant Management	*Effective Acute Phase Treatment*	40.92%
	Effective Continuation Phase Treatment	24.50%
Timeliness of Prenatal Care		93.62%
Comprehensive Diabetes Care - CDC (SPD)	*HbA1c Testing*	87.85%
	Patients with Diabetes received Statin Therapy	56.07%
Adults & Children: Asthma ages 5-64	*(AMR) Total*	71.28%
Adults: Pharmacotherapy Management of COPD Exacerbation (PCE)	*Systemic Corticosteroid*	43.57%

VIII. Section 11, REPORTING REQUIREMENTS, is amended to add the following:

The Division requires the Contractor to submit reports and data required by federal, state, and other regulatory agencies. This includes the CMS Annual Managed Care Program Report, and all other required reports.

AA. CMS Annual Managed Care Program Report

The Contractor shall provide its CMS Annual Managed Care Program Report to the Division no later than ninety (90) days following each contract year in order for the Division to meet the requirements of 42 C.F.R. § 438.66(e).

Contractor shall submit its annual Managed Care Program Report in accordance with 42 C.F.R. § 438.66(e) which shall include following information:

1. Financial performance of each MCO, PIHP, and PAHP, including MLR experience.
2. Encounter data reporting by each MCO, PIHP, or PAHP.
3. Enrollment and service area expansion (if applicable) of each MCO, PIHP, PAHP, and PCCM entity.
4. Modifications to, and implementation of, MCO, PIHP, or PAHP benefits covered under the contract with the State.
5. Grievance, appeals, and State fair hearings for the managed care program.
6. Availability and accessibility of covered services within the MCO, PIHP, or PAHP contracts, including network adequacy standards.
7. Evaluation of MCO, PIHP, or PAHP performance on quality measures, including as applicable, consumer report card, surveys, or other reasonable measures of performance.
8. Results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.
9. Activities and performance of the beneficiary support system.
10. Any other factors in the delivery of LTSS not otherwise addressed in (e)(2)(i)-(ix) of this section as applicable.

IX. Section 13.A.9., CAPITATION RATES, is amended to read as follows:

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 2022 (July 1, 2021 through June 30, 2022).

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

UnitedHealthcare of Mississippi
Capitation Rates (including Risk Scores)
Effective July 1, 2021 – December 31, 2021

Region	North			Central			South		
Rate Cell	Rate	Risk Adj	Total Rate	Rate	Risk Adj	Total Rate	Rate	Risk Adj	Total Rate
Original Population									
SSI-Disabled	$1,067.45	1.003	$1,070.22	$1,250.51	0.960	$1,200.16	$1,254.07	0.978	$1,226.25
Foster Care	$667.13	0.962	$641.88	$698.57	0.915	$639.41	$682.17	0.931	$634.96
Breast/Cervical	$3,399.78	-	$3,399.78	$3,982.81	-	$3,982.81	$3,994.17	-	$3,994.17
SSI-Disabled Newborn	$8,469.12	-	$8,469.12	$8,868.28	-	$8,868.28	$8,660.02	-	$8,660.02
Expansion Population									
MA Adults	$464.99	1.001	$465.40	$517.26	1.012	$523.53	$494.58	1.014	$501.57
Pregnant Women	$1,111.83	-	$1,111.83	$1,236.81	-	$1,236.81	$1,182.57	-	$1,182.57
Non-SSI Newborns 0-2 Months	$2,028.27	-	$2,028.27	$2,123.87	-	$2,123.87	$2,073.99	-	$2,073.99
Non-SSI Newborns 3-12 Months	$278.59	-	$278.59	$291.72	-	$291.72	$284.87	-	$284.87
MA Children	$215.14	1.022	$219.84	$225.28	1.017	$229.12	$219.99	1.027	$225.90
Quasi-CHIP	$217.17	1.023	$222.16	$227.41	0.996	$226.50	$222.07	1.035	$229.84
MYPAC	$4,104.59	-	$4,104.59	$4,298.04	-	$4,298.04	$4,197.11	-	$4,197.11

*Capitation rate per April 21, 2021 Actuarial report and Risk Score per January 18, 2022 Actuarial report included as Exhibit 1 to this Amendment.
**The risk score displayed on this amendment is truncated and may reflect rounding differences in the Total Rate paid to CCO.

UnitedHealthcare of Mississippi
Capitation Rates (including Risk Scores)
Effective January 1, 2022 – June 30, 2022

Region	North			Central			South		
Rate Cell	Rate	Risk Adj	Total Rate	Rate	Risk Adj	Total Rate	Rate	Risk Adj	Total Rate
Original Population									
SSI-Disabled	$1,067.45	0.997	$1,064.18	$1,250.51	0.963	$1,204.28	$1,254.07	0.966	$1,211.55
Foster Care	$667.13	1.047	698.62	$698.57	1.013	$707.51	$682.17	1.028	$701.25
Breast/Cervical	$3,399.78	-	$3,399.78	$3,982.81	-	$3,982.81	$3,994.17	-	$3,994.17
SSI-Disabled Newborn	$8,469.12	-	$8,469.12	$8,868.28	-	$8,868.28	$8,660.02	-	$8,660.02
Expansion Population									
MA Adults	$464.99	1.008	$468.49	$517.26	1.007	$520.73	$494.58	1.010	$499.73
Pregnant Women	$1,111.83	-	$1,111.83	$1,236.81	-	$1,236.81	$1,182.57	-	$1,182.57
Non-SSI Newborns 0-2 Months	$2,028.27	-	$2,028.27	$2,123.87	-	$2,123.87	$2,073.99	-	$2,073.99
Non-SSI Newborns 3-12 Months	$278.59	-	$278.59	$291.72	-	$291.72	$284.87	-	$284.87

MA Children	$215.14	1.026	$220.70	$225.28	1.017	$229.14	$219.99	1.029	$226.30
Quasi-CHIP	$217.17	1.016	$220.64	$227.41	1.021	$232.17	$222.07	1.040	$230.96
MYPAC	$4,104.59	-	$4,104.59	$4,298.04	-	$4,298.04	$4,197.11	-	$4,197.11

*Capitation rate per April 21, 2021 Actuarial report and Risk Score per January 18, 2022 Actuarial report as Exhibit 1 to this Amendment.

**The risk score displayed on this amendment is truncated and may reflect rounding differences in the Total Rate paid to CCO.

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.

X. Section 13.F. – FINANCIAL REQUIREMENTS is amended to read as follows:

F. Federal, State, and Local Taxes

The Contractor shall pay taxes lawfully imposed upon it with respect to this Contract or any product delivered in accordance herewith. The Division makes no representation whatsoever as to the exemption from liability to any tax imposed by any governmental entity on the Contractor. In no event will the Division be responsible for the payment of taxes for which the Contractor may be liable as a result of the Contract.

The Division incorporates the full three percent (3%) Premium Tax, as required by Miss. Code Ann. § 27-15-103, into the Capitation Payment. The Contractor is expected to remit to the Mississippi Department of Revenue the full three-percent (3%) Premium Tax. If Contractor does not remit the full three percent (3%) Premium Tax to the Mississippi Department of Revenue through any available credits, reductions, deductions, or any other permissible offsets allowed under State law, then Contractor shall remit the total amount of credits, reductions, deductions or other permissible offsets allowed under state law, as applicable to Capitation Payments, to the Division within ten (10) business days of filing its annual insurance premium tax return with the State.

On an annual basis, within ten (10) business days of filing with the State, the Contractor will provide sufficient documentation of such payments to the Division, including but not limited to proof of calculations used to arrive at the payment amounts, the Mississippi income tax return (Corporate Income and Franchise Tax Return or Insurance Company Income Tax Return), Mississippi insurance premium tax return and proof of remittance of such taxes to the Mississippi Department of Revenue.

XI. Section 16., DEFAULT AND TERMINATION, the first paragraph of Subsection A – Sanctions, is amended to read as follows and Subsection O – Recoupment of Rework Costs is added as an additional provision:

A. Sanctions

In the event the Division finds the Contractor to be non-compliant with program standards, performance standards, provisions of this Contract, or the applicable statutes or rules governing Medicaid prepaid health plans, the Division may, without limitation to other available remedies contained herein or otherwise available at law, issue a written notice of deficiency, request a corrective action plan, and/or specify the manner and time frame in which the deficiency is to be cured. Performance standards shall not be less than ninety-eight percent (98%) unless otherwise specified in this Contract or other State written requirements and shall apply to the Contractor and its Subcontractors. If the Contractor fails to cure the deficiency as ordered to the satisfaction of the Division, the Division shall have the right to exercise any of the administrative sanction options described in this section, in addition to any other rights and remedies that may be available to the Division:

O. Recoupment of Rework Costs

If the Contractor's failure to satisfactorily perform necessitates Rework by the Division, the Division may offset the Contractor payments in the amount commensurate with the costs incurred by the Division and/or is Agent for Rework. The Division shall account to the Contractor all costs incurred. The need for Rework will be determined at the Division's sole discretion.

XII. Section 18.A., CLAIMS MANAGEMENT – Claims Payment, is amended to add the following:

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 Section 7.J of the Contract which states that "The Contractor shall reimburse all Network Providers at a rate no less than the amount that the Division reimburses fee-for-service providers with the exception of capitation and other incentive arrangements under Section 7.K, Physician Incentive Plans, of this Contract and such innovative payment models authorized under Miss. Code Ann. § 43-13-117 (H)."

XIII. Exhibit D: MEMBER COMPLAINT, GRIEVANCE, APPEAL, AND STATE FAIR HEARING PROCESS. The first full paragraph of Exhibit D (page 266) is amended to read as follows:

The following parties have a right to file a Complaint, Grievance, and Appeal on behalf of the Member in compliance with 42 C.F.R. § 438.402(c)(ii):

1. The legal guardian of the Member for a minor or incapacitated adult,
2. An authorized representative of the Member as designated in writing to the Contractor, or
3. A service Provider acting as Member's authorized representative through the Member's written consent.

XIV. Exhibit D: MEMBER COMPLAINT, GRIEVANCE, APPEAL, AND STATE FAIR HEARING PROCESS. Paragraph 4 of Exhibit D, Subsection C – Appeal: A request for review by the Contractor of an Adverse Benefit Determination, is amended to read as follows:

The Contractor shall have a process in place that ensures that a verbal or written inquiry from a Member seeking to Appeal an Adverse Benefit Determination is treated as an Appeal (to establish the earliest possible filing date for the Appeal). A written appeal is not required to be filed by the member to request an Appeal.

XV. Exhibit H: REPORTING REQUIREMENTS. Contractor Administrative Reporting Frequency and Timeframe for "Fee Schedule Validation" is amended as follows:

Fee Schedule Validation	Quarterly	30th Calendar day after the close of the Quarter

XVI. 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 Twelve.

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

Mississippi Division of Medicaid

By: _____
Drew L. Snyder
Executive Director

Date: 2/7/2022

UnitedHealthcare of Mississippi, Inc.

By: _____
J. Michael Parnell
Chief Executive Officer

Date: 2/4/2022

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 Twelve** 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 7th day of February, A.D., 2022.

NOTARY PUBLIC

Shelby J Berryman

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

My Commission Expires:

Sept 23, 2024

STATE OF MS
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 Twelve** 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 4 day of February A.D., 2022.

NOTARY PUBLIC

STATE OF MISSISSIPPI JENNIE JENKINS NOTARY PUBLIC ID No. 120014 Commission Expires April 30, 2025 RANKIN COUNTY

My Commission Expires: