AMENDMENT NUMBER SEVEN
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. – Children's Health Insurance Program)

THIS AMENDMENT NUMBER SEVEN 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 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 § 457.1201 and is engaged in the business of providing prepaid comprehensive health care services as defined 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) 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 Seven; and,

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, and #6;

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 term of this Contract shall commence on August 1, 2019, and shall expire on July 31, 2023, unless this Contract is terminated pursuant to Section 15, Non-Compliance and Termination. The Division has under the same terms and conditions as the existing Contract and any subsequent amendments, the option for one (1) one-year extension.

II. Section 7.E., PROVIDER NETWORK – Provider Credentialing and Qualifications is amended to add the following language:

E. Provider Credentialing and Qualifications

Pursuant to *Miss. Code Ann. §43-13-117(H)(6),* 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 Mississippi CHIP Providers as established or approved by the Division. Effective October 3, 2022, the 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 and certify to the Division that all Network Providers and any Out-of-network Providers to whom Members may be referred are properly licensed in accordance with all applicable State law and regulations, are eligible to participate in CHIP, and have in effect appropriate policies of malpractice insurance as may be required by the Contractor and the Division. The Contractor must ensure that all Network Providers submit disclosure, and meet screening and enrollment requirements of 42 C.F.R. part 455, subparts B and E. This provision does not require the Network Provider to render services to fee-for-service Members. Effective October 3, 2022, Contractor shall accept the Division's provider master file as evidence that Providers have met the requirements of 42 C.F.R. part 455, subparts B and E.

All Contractor Network Providers must submit the appropriate National Provider Identifier (NPI) numbers to the Division in accordance with the currently established process. Contracted nurse practitioners acting at PCPs shall be held to the same requirements and standards as physicians acting as 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.

Until October 3, 2022, in contracting with Providers, the Contractor will be responsible for obtaining all disclosure information from all Network Providers and Out-of-network Providers and abide by all applicable Federal regulations, including 42 C.F.R. § Part 455.104, and Subparts B and E §455.106 during the screening and enrolling process.

Until October 3, 2022, the Contractor shall maintain a file for each Provider containing complete Provider application including a signed attestation statement, a copy of the Provider's current license issued by the State, a valid DEA or Controlled Dangerous Substances certificate; proof cover page of malpractice insurance (copy of certificates or cover pages), and such additional information as may be specified by the Division.

Until October 3, 2022, in contracting with laboratory Providers and or any Provider who bills for laboratory services, the Contractor must ensure that all laboratory testing sites providing services under the Contract have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. Provider attestation of CLIA certificate is not acceptable. The Contractor shall maintain copies of the CLIA certificate or waiver of the certificate of registration in the Provider's credentialing and recredentialing files.

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

After October 3, 2022, 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

Practitioners shall be allowed to review the information utilized in the decision making process related to the practitioner's credentialing application. Credentialing operation and requirements are documented through the Division's Fiscal Agent and will be available to practitioners.

The Contractor shall notify the Division within ten (10) calendar days of the Contractor's denial of a Provider request to contract either 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.

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

The Contractor must submit reports in accordance with Section 10.E, Provider Services Reports, of this Contract.

III. Section 7.J., PROVIDER NETWORK - Reimbursement, is amended to add the following:

3. 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.

IV. Section 10.E., REPORTING REQUIREMENTS – Provider Services Reports, is hereby amended to read as follows:

E. Provider Services Reports

The Contractor shall submit a monthly and 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 12.A.9, CAPITATION PAYMENTS – Capitation Rates, is 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, 2022 through June 30, 2023 is $250.02. (See Exhibit 1 to this Amendment 7).

VI. Section 12.A.10., CAPITATION PAYMENTS – Risk Corridor, is amended to add the following:

10. <u>Risk Corridor</u>

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 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 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 purposes of the SFY 2023 risk corridor, a different definition of the MLR will be used than the Federal MLR definition. The last column of Exhibit 3 from the April 20, 2022 rate certification letter "Report06 – SFY 2023 Preliminary CHIP Rate Calculation and Certification" illustrates the calculation of the target MLR for the Contractor and is hereby attached and incorporated as Exhibit 1 to this Amendment 7.

The 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 2023 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) Adjustments to revenue and claims resulting from the MLR audit will be incorporated into the calculation of each CCO's actual MLR.
4) The 85% minimum MLR provision in Section 12.E 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 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 15.E., NON-COMPLIANCE AND TERMINATION – Liquidated Damages, Table 9. Monetary Damages, 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 9, Monetary Damages of Section 15.E., NON-COMPLIANCE AND TERMINATION – Liquidated Damages remain unchanged through this Amendment 7 and in full force and effect as agreed to by the Parties within Amendment #4, Attachment A.

VIII. 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 Seven.

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

Division of Medicaid:

By: _____
Drew L. Snyder
Executive Director

Date: June 3, 2022

Molina Healthcare of Mississippi, Inc.

By: _____
Bridget Galatas
Plan President & Chief Executive Officer

Date: June 2, 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 Seven** 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 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 she signed and delivered the above and foregoing written **Amendment Number Seven** 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