AMENDMENT NUMBER EIGHT
TO THE CONTRACT BETWEEN
THE DIVISION OF MEDICAID
IN THE OFFICE OF THE GOVERNOR
AND
MOLINA HEALTHCARE OF MISSISSIPPI, INC.
A CARE COORDINATION ORGANIZATION (CCO)

(Molina Healthcare of Mississippi, Inc. – Children's Health Insurance Program)

THIS AMENDMENT NUMBER EIGHT 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 §§ 438.3(b) and 457.1201 and is engaged in the business of providing comprehensive services as outlined 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) of the Social Security Act 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 Eight;

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, #6, and #7.

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 CHIP in accordance with the State Health Plan. Coverage includes the Mississippi Division of Medicaid State Plan, also known as the Benchmark Plan, plus additional coverage and the Contractor shall provide Covered services set forth in Exhibit B, Covered Services, of this Contract. The Contractor shall ensure that all covered services are accessible to Members (in terms of timeliness, amount, duration, and scope); that no incentive is provided, monetary or otherwise, to Providers for withholding Medically Necessary covered services from a Member. The Contractor guarantees it will not avoid costs for covered services by referring Members to publicly supported resources, in accordance with 42 C.F.R. § 457.1201(p). 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 will not impose any pre-existing medical condition exclusion for covered services contained in this Contract, in accordance with 42 C.F.R. § 457.480 and Section 2102(b)(1)(B)(ii) of the Social Security Act.

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 12.A.9, CAPITATION PAYMENTS – Capitation Rates, is amended to add the following:

9. **Capitation Rate**

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, 2021 through June 30, 2022 is $264.98. (See Exhibit 1 to this Amendment 8).

III. Section 10.Q.3, REPORTING REQUIREMENTS – Encounter Data is hereby amended to read as follows:

3. Encounter Submissions

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 settled 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 Subcontractors 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 threshold error rates as defined in Section 15.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 15, Non-Compliance and Termination, of this Contract for non-compliance with these timeliness 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 15, Non-Compliance 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 15, Non-Compliance and Termination, of this Contract for non-compliance.

IV. EXHIBIT D: MEDICAL LOSS RATIO (MLR) REQUIREMENTS is hereby amended and replaced with "EXHIBIT D: MEDICAL LOSS RATIO (MLR) REQUIREMENTS" as attached and incorporated herein by reference to this Amendment 8.

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 Eight.

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

Division of Medicaid:

By: _____
Drew L. Snyder
Executive Director

Date: 10/25/22

Molina Healthcare of Mississippi, Inc.

By: Bridget Galatas
Bridget Galatas
Plan President & Chief Executive Officer

Date: 10/18/2022

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 Eight** 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

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 Eight** 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 18th day of October, A.D., 2022.

STATE OF MISSISSIPPI
NORMA L DEMPSEY
NOTARY PUBLIC
ID No. 99181
Commission Expires
June 16, 2023
HINDS COUNTY

NOTARY PUBLIC

My Commission Expires:

June 16, 2023