AMENDMENT NUMBER SIX
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 SIX 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 Five; 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, and #5;

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 I, GENERAL PROVISIONS, is amended to add the following:

R. 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 7.J.1. PROVIDER NETWORK – Reimbursement; Claims Payment, Denial, and Appeals, 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 Miss. Code Ann. § 43-13-117 (H).

IV. Section 6.A.6., 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 External Review 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.B., 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 Children's Health Insurance Program (CHIP) Annual Report Template System (CARTS), the CMS Annual Managed Care Program Report, and all other required reports.

VIII. Section 10., REPORTING REQUIREMENTS, is amended to add the following

subsection:

BB. CMS Annual Managed Care Program Report

The Contractor shall provide to its CMS Annual Managed Care Program Report to the Division by 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 12.D., FINANCIAL REQUIREMENTS, is amended to read as follows:

Unless otherwise provided herein, the Contract price shall include all applicable federal, state, and local taxes. The Contractor understands and agrees that the State is exempt from the payment of 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 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.

X. Section 15., NON-COMPLIANCE AND TERMINATION, the first paragraph Subsection A – Sanctions is amended to read as follows and Subsection N – Recoupment of Rework Costs is added as an additional provision:

A. Sanctions

In the event the Division finds the Contractor to be non-compliance 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 that may be available to the Division:

N. 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.

XI. Exhibit E: MEMBER COMPLAINT, GRIEVANCE, APPEAL, AND STATE FAIR HEARING PROCESS. Subsection A(21) (page 252) 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.

XII. Exhibit E: MEMBER COMPLAINT, GRIEVANCE, APPEAL, AND STATE FAIR HEARING PROCESS. Paragraph 5 of Exhibit E, Subsection D – 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.

XIII. 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 Six.

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

Division of Medicaid:

By: _____
Drew L. Snyder
Executive Director

Date: 2/10/2022

Molina Healthcare of Mississippi, Inc.

By: _____
Bridget Galatas
Plan President & Chief Executive Officer

Date: 2/10/2022

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 Six** 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 10th day of February, 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 Six** 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 10th day of February, A.D., 2022.

STATE OF MISSISSIPPI
NORMA L DEMPSEY
NOTARY PUBLIC
ID No. 98181
Commission Expires
June 16, 2023
HINDS COUNTY

NOTARY PUBLIC

My Commission Expires:

June 16, 2023