AMENDMENT NUMBER TEN
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 TEN 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 Ten;

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, #7, #8, and #9.

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:

1. Section 2.A, DEFINITIONS is hereby amended to add the following definition:

    95. **Certified Community Behavioral Health Clinic (CCBHC):** a specially designated clinic that provides a comprehensive range of mental health and substance use services in accordance with federal criteria and with the requirements of the Protecting Access to Medicare Act of 2014 (PAMA). Certified Community Behavioral Health Clinic (CCBHC) as defined in Section 223 PAMA and Section 3814 CARES Act.

2. Section 2.B., ACRONYMS is hereby amended to add the following:

    53. CCBHC – Certified Community Behavioral Health Clinic

3. Section 7.D.1, PROVIDER NETWORK – Provider Terminations – Terminations by the Contractor, is hereby amended to only revise the language of the second paragraph under subsection 1 as follows:

    1. Termination by the Contractor

    For PCPs and hospital terminations and at the discretion of the Division, the Contractor must submit a Provider termination work plan and supporting documentation within ten (10) business days of the Contractor's notification to the Division of the termination and must provide weekly updates to this information. The Division may also request Provider termination work plans and supporting documentation for other Provider types. This work plan shall document work steps and due dates and, as applicable, may include, but is not limited to the submission of:

        a. Provider Impact and Analysis;
        b. Updated Provider Network and/or Provider Affiliation File;
        c. Provider Notification of the Termination;
        d. Member Impact and Analysis;
        e. Member Notification of the Termination;
        f. Member Transition and Continuity of Care;
        g. Systems Changes;
        h. Provider Directory Updates for the Division's Agent (include date when all updates will appear on Provider files);
        i. Contractor Online Directory Updates;

j. Submission of Required Documents to the Division (Member notices for prior approval);
k. Submission of Final Member Notices to the Division;
l. Communication with the public related to the termination; and
m. Termination Retraction Plan, if necessary.

All other language not modified as stated herein for Section 7.D.1 shall remain unchanged and in full force and effect.

4. Section 7.D.2, PROVIDER NETWORK – Provider Terminations – Terminations by the Provider, is hereby amended to only revise the language of the second paragraph under subsection 2 as follows:

2. Termination by the Provider

At the discretion of the Division, Contractor must submit a Provider termination work plan that may include, as applicable, the elements listed in Section 7.D.1, Termination by the Contractor, above within ten (10) business days of the Contractor notifying the Division of the termination and must provide monthly status updates to the work plan. All other language not modified as stated herein for Section 7.D.2 shall remain unchanged and in full force and effect.

5. Section 7.J.1., PROVIDER NETWORK – Reimbursement; Claims Payment, Denial, and Appeals, is hereby amended to remove and delete the following Amendment 6 language:

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).

All other language not modified as stated herein for Section 7.J.1 shall remain unchanged and in full force and effect.

6. Section 10.P., REPORTING REQUIREMENTS – Health Information System, is hereby amended to add the following:

The Contractor shall work with the IT/Data Systems Work Group of the Mississippi Certified Community Behavioral Health Clinic (CCBHC) Planning Grant Steering Committee to define a mutual statement of work and schedule to

implement software and hardware routing solutions required for the successful implementation of CCBHCs.

7. Section 10.S., REPORTING REQUIREMENTS - Claims Processing and Information Retrieval Systems, is hereby amended to add the following:

   In preparation for the planned CCBHC program to be initiated at a future date upon authorization by the Division, the Contractor shall, as requested by the Division, provide resources and initiate participation in the IT/Data Systems Workgroup of the Mississippi Certified Community Behavioral Health Clinic (CCBHC) Planning Grant Steering Committee to ensure their claims systems are prepared to process claims with the new CCBHC provider type.
   Contractor shall provide appropriate Subject Matter Experts (SMEs) experienced with CCBHC operations and systems as requested by the Division to participate in regularly scheduled CCBHC meetings as coordinated by the Division. Contractor SMEs shall provide input at the scheduled CCBHC meetings relative to planning, implementation, and operation of the CCBHC program.

   In accordance with the requirements of PAMA, the Division will establish a prospective payment system (PPS) rate for the payment of CCBHC services. This PPS rate will cover all services provided to a beneficiary on a daily basis for all of the services included in the scope of services of the CCBHC. The Contractor will be required to initiate and prepare their internal payment systems to incorporate this PPS rate methodology.

8. Section 12.A.9., FINANCIAL REQUIREMENTS – Capitation Rate, is hereby 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, 2023 through June 30, 2024 is $260.82. (See Exhibit 1 to this Amendment 10).

9. Section 12.A.10., FINANCIAL REQUIREMENTS – Risk Corridor, is hereby amended to add the following:

   10. Risk Corridor- State Fiscal Year (SFY) 2024
   (a) Program-Wide Risk Corridor – State Fiscal Year (SFY) 2024

Subject to CMS approval, the Division will implement a symmetrical program-wide risk corridor for the timeframe of July 1, 2023 through June 30, 2024 ("SFY 2024") to address the uncertainty of medical costs related to the federally required COVID-19 Public Health Emergency (PHE) unwinding during SFY 2024. The program-wide risk corridor was developed in accordance with generally accepted actuarial principles and practices.

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 program-wide 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 2024 Program-Wide 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 2024 Program-Wide Risk Corridor, a different definition of the MLR will be used than the Federal MLR definition. The last column of **Exhibit 3** from the September 27, 2023 certification letter illustrates the calculation of the target MLR for the Contractor and is hereby attached and incorporated as Exhibit 1 to this Amendment10.

The Program-Wide 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 2024 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) The High-Cost Pharmacy Risk Corridor will be calculated independent of the Program-Wide Risk Corridor. Costs and premiums associated with the High-Cost Pharmacy Risk Corridor will not be accounted for or included in the calculation of the Program-Wide Risk Corridor.

4) Adjustments to revenue and claims resulting from the MLR audit will be incorporated into the calculation of each CCO's actual MLR.

5) The 85% minimum MLR provision in Section 12.E of the Contract will apply after the risk corridor settlement calculation.

The initial program-wide risk corridor calculation and settlement will occur using the SFY 2024 values included in the annual MLR report submitted from the Contractor to the Division with six (6) months of runout. Any payment or recoupment between the Division and Contractor based on this initial settlement will occur in the month of May after the close of the state fiscal year. A final calculation of payments or recoupments as a result of the program-wide risk corridor will occur once the MLR audit has been completed, typically 12 to 18 months after the close of the state fiscal year.

(b) Risk Corridor for Pharmacy High-Cost Drugs - State Fiscal Year (SFY) 2024

Some Medicaid members have conditions requiring very expensive drug treatments. These members are infrequent and not evenly distributed among the CCOs. To help mitigate the CCO's risk, the state is introducing a pharmacy high-cost drug risk corridor for SFY 2024, subject to CMS approval. The pharmacy high-cost drug risk corridor is applicable to total drug spend of $500,000 or more per year at a member level. The capitation rates include a PMPM estimate of the costs that will be covered in the pharmacy high-cost drug risk corridor specific to each population. The actual costs from the CCOs will be compared to these estimated costs for the final settlement calculation.

The pharmacy high-cost drug risk corridor outlined below has been developed in accordance with generally accepted actuarial principles and practices. The table below summarizes the share of gains and losses relative to the estimated high-cost pharmacy costs for each party.

Mississippi Division of Medicaid Risk Corridor Parameters for Pharmacy High-Cost Drugs SFY 2024		
Contractor Gain/Loss	**Contractor Share of Gain/Loss in Corridor**	**Division Share of Gain/Loss in Corridor**
Less than -6.0%	0%	100%
-6.0% to -3.0%	50%	50%
-3.0% to +3.0%	100%	0%
+3.0% to +6.0%	50%	50%
Greater than +6.0%	0%	100%

The pharmacy high-cost drug risk corridor will be implemented using the following provisions:

(1) Estimated high-cost pharmacy costs will be calculated separately for each Rate Cell based on the expected mix of high-cost products.

(2) Each Rate Cell's actual high-cost pharmacy costs will include payments made for the following:

(a) All pharmacy claims with an NDC code billed through a retail or specialty pharmacy, regardless of where these claims are administered.

(b) All drugs billed as medical claims with a HCPCS code that starts with the letter "J"

(c) Inpatient stays for select gene therapies and other select products. The estimated pharmacy costs included in the high-cost risk corridor include the following; however, DOM will monitor and revise the list of approved products if additional products are covered by DOM for use during SFY 2024.

i) lovotibeglogene autotemcel (lovo-cel)
ii) exagamglogene autotemcel (exa-cel)
iii) Zynteglo

(d) Applicable script limits will be applied and the costs for those services will not be counted toward total member spend during that time period.

(3) The timing of the pharmacy high-cost drug risk corridor settlements will occur during the initial and final settlements for the program-wide risk corridor. The pharmacy high-cost risk corridor will be calculated independently of the larger program-wide risk corridor. Costs and premiums associated with the High-Cost Pharmacy Risk Corridor will not be

accounted for or included in the calculation of the Program-Wide Risk Corridor.

(a) The initial settlement will occur after the contract year is closed, using six months of runout. Any payment or recoupment between the Division and Contractor based on this initial settlement will occur in the month of May after the close of the state fiscal year.

(b) The final settlement will occur once the MLR audit has been completed. MLR audits are usually completed 12 to 18 months after the close of the SFY.

(4) The 85% minimum MLR provision (Federal MLR definition) in the CCO contract will apply after the risk corridor settlement calculation.

10. 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 10.

All other terms, conditions, and provisions of the Contract and any subsequent amendments, other than those modified herein, remain in full force and effect for the duration of the Contract.

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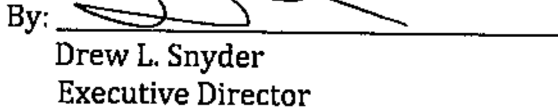
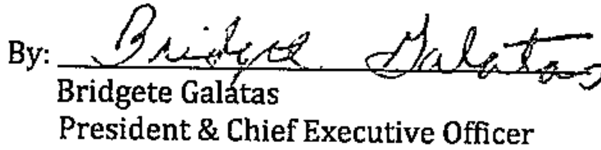
IN WITNESS WHEREOF, the parties have executed this Amendment Number Ten by their duly authorized representatives.

Division of Medicaid:

By: 
Drew L. Snyder
Executive Director

Date: 12/11/23

Molina Healthcare of Mississippi, Inc.

By: 
Bridgete Galátas
President & Chief Executive Officer

Date: 10/17/2023

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 Ten** 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 11th day of December, A.D., 2023.

NOTARY PUBLIC

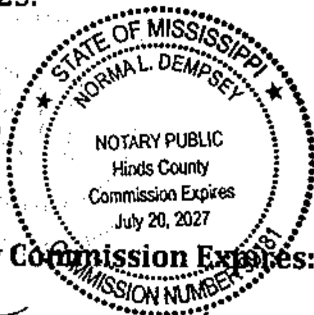
My Commission Expires:

Sept 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, **Bridgete Galatas,** in her respective capacity as the **President & 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 he signed and delivered the above and foregoing written **Amendment Number Ten** 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 17th day of October, A.D., 2023.



NOTARY PUBLIC

My Commission Expires:

July 20, 2027