Amendment Number 3
to
Contract #30-2021-061-DHB Primary Care Case Management Entity
Between
North Carolina Department of Health and Human Services, Division of Health Benefits
And
North Carolina Community Care Networks, Inc.

THIS Amendment Number 3 (this "Amendment") to Contract #30-2021-061-DHB Primary Care Case Management Entity effective September 28, 2021 (as amended, collectively, the "Contract") is between the North Carolina Department of Health and Human Services, Division of Health Benefits ("Department"), and North Carolina Community Care Networks, INC ("Contractor"), a primary care case management (PCCM) entity defined by 42 C.F.R. § 438.2. Capitalized terms used but not defined in this Amendment shall have the meanings ascribed to such terms in the Contract. The Department and Contractor are Each referred to as, a "Party" and collectively referred to as, the "Parties".

Background:
The purpose of this Amendment is to make technical and regulatory corrections, update PCCM fees, and amend reporting due dates in the following sections of the Contract:

1. Section III. Contract Term. General Terms and Conditions, and Other Provisions & Protections
2. Section IV. Scope of Services
3. Contract Attachments

Now, therefore, in consideration of the terms and conditions contained in this Amendment and for other good and valuable consideration, the receipt and legal sufficiency of which are acknowledged, and intending to be legally bound, The Parties agree as follows:

I. Amendments to Section III. Contract Term, General Terms and Conditions, Other Provisions & Protections

The following subsection is amended as follows:

a. Section III, B. General Terms and Conditions, 35. PAYMENT AND INVOICING, f. Payment for COVID-19 Vaccination Enrollee Incentive Program is amended and restated as follows:

f. Payment for COVID-19 Vaccination Enrollee Incentive Program

i. The Department will make payments to the Contractor for up to one million dollars ($1,000,000) in SFY23 for the administration of the COVID-19 Vaccination Enrollee Incentive Program.

ii. The Contractor shall limit Enrollee incentives to no more than one hundred dollars ($100) per Enrollee during SFY23.

iii. The Department will provide reimbursement for the administration and payment of incentives in the Contractor's COVID-19 Vaccination Enrollee Incentive Program. The Department will limit reimbursement to the Contractor for the administration

of the COVID-19 Vaccination Enrollee Incentive Program to no more than twenty percent (20%) of the total payments to the Contractor.
iv. The Department will make payment to the Contractor sixty (60) Calendar Days after receipt of a clean COVID-19 Vaccination Enrollee Incentive Program Report from the Contractor for incentives provided to Enrollees for vaccines administered through December 31, 2022.

II. Amendments to Section IV. Scope of Services

The following subsections are amended as follows:

a. Section IV, A. Enrollees, 1. Eligibility to Enroll in the PCCM Entity, e. ii.-iii. are amended and restated as follows:

ii. Exempt PCCM Enrollment with opportunity to opt-in:

1. Beneficiaries who are members of federally recognized tribes or otherwise exempt from mandatory managed care enrollment as defined in 42 § C.F.R. 438.50(d) and 42 C.F.R. § 438.14(a)

iii. Exempt PCCM Enrollment with opportunity to opt-out and defined in the NC Medicaid State Plan:

1. "Dual Eligibles" not described under Medicare Savings Program - Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing
2. Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.
3. Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E
4. Non-Title IV-E Adoption Assistance Under Age 2
5. Reside in Nursing Facility or ICF/IID-- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).
6. Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

b. Section IV, A. Enrollees, 2,. PCCM Enrollment and Disenrollment is amended to add the following:

f. All enrolled beneficiaries shall receive Enrollment Notice from the Department based on the format and process determined by the Department. 42 C.F.R. § 438.10(c)(4)(ii).

g. All enrolled beneficiaries shall have the right to do the following:
   i. Disenroll from the PCCM program for cause, anytime. 42 C.F.R. § 438.56(c)(1).

ii. Disenroll from the PCCM program without cause at any time the Department imposes the intermediate sanction on the Contractor specified in §438.702(a)(4). 42 C.F.R. § 438.56(c)(2)(iv).

h. The Department shall define the effective date of an approved disenrollment to be no later than the first day of the second month following the month in which the enrollee requests disenrollment. 42 C.F.R. § 438.56(e)(1).

i. If the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the effective date that would have been established.
    i. Any Indian enrolled in the PCCM program eligible to receive services from an IHCP PCP must be permitted to choose that IHCP as their PCP, as long as that provider has capacity to provide the services. American Reinvestment and Recovery Act (ARRA) 5006(d); 42 C.F.R. § 457.1209; 42 C.F.R. 438.14(b)(3)

j. The Contractor shall notify the Department monthly using the Change in Member Circumstances Report as described in Attachment B. Deliverables and Reporting Requirements upon identification of any information about a Member's circumstances that may affect the Member's Medicaid or NC Health Choice eligibility, including changes in the Member's residence, such as out-of-state claims, or the death of the Member.

c. Section IV, A. Enrollees, 3. Enrollee Engagement, e. Communications with enrollees, iv. is amended and restated as follows:

iv. In accordance with 42 C.F.R. § 438.10(c)(6), the Contractor shall ensure any Contractor-created materials that are provided electronically to enrollees are:
    1. In a format that is readily accessible;
    2. In an electronic form which can be electronically retained and printed;
    3. Consistent with content and language requirements of 42 C.F.R. § 438.10;
    4. made available in paper form without charge upon request and provided to enrollee within five (5) business days of the request; and
    5. placed in a location on the Department's website, that is prominent and readily accessible.

d. Section IV, A. Enrollees, 3. Enrollee Engagement, g. Mailing Materials to Enrollees, i-ii is amended and restated as follows:

i. The Contractor shall notify the Department monthly of all returned mail due to incorrect mailing address in an electronic format defined by the Department in subsequent guidance, as described in Attachment B. *Deliverables and Reporting Requirements*.
ii. If the Contractor identifies a new, updated address, the Contractor shall:

1. Resend only Member specific information at no additional cost to the Department or the Member; and
2. Notify the Department using the Non-Verifiable Member Addresses and Returned Mail Report as described in *Attachment B. Second Revised and Restated Deliverables and Reporting Requirements*.

e. Section IV, A. Enrollees, 3. Enrollee Engagement, j. Enrollee Handbook is amended to add the following:

vii. The Contractor shall revise the Enrollee Handbook and submit to the Department for review prior to implementing any significant changes to the PCCM program that will impact enrollees. The Revised Enrollee Handbook must be approved by the Department and published in the Enrollee Welcome Letter at least 30 Calendar Days prior to the effective date of the change.

f. Section IV, B. Benefits and Care Management. 4. Care Management for Children in Foster Care. a. is amended and restated as follows:

4. Care Management for Children in Foster Care
   a. Children in Foster Care not eligible for Tailored Care Management are defined by the eligibility codes provided by the Department on the enrollment files sent to Contractor. Upon launch of Tailored Care Management, the contractor will not serve foster Children eligible for Tailored Care Management. The department is responsible for notifying the contractor of foster care beneficiaries that opt out of Tailored Care Management.

g. Section IV, B. Benefits and Care Management. 4. Care Management for Children in Foster Care. e. v. is amended and restated as follows:

v. The Contractor will attempt to perform care needs screenings annually on each Enrollee.

h. Section IV, B. Benefits and Care Management is amended to add the following:

5. Cost Avoidance

The Contractor must guarantee that it will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. 42 C.F.R. 457.1201(p)

i. Section IV, H. Compliance, 3. Fraud, Waste and Abuse Prevention is amended and restated as follows:

3. Fraud, Waste, and Abuse Prevention

   a. To promote integrity in all PCCM entity activities and combat fraud, waste, and abuse, the Contractor shall:

i. Investigate suspected allegations of Medicaid fraud, waste, or abuse involving its staff.
The Contractor shall refer allegations to the Department, using the Department's defined Fraud, Waste, and Abuse Submission Form, within five (5) days of making a determination of fraud, abuse or waste.
ii. Develop and implement a fraud, waste, and abuse policy for its staff.
iii. Provide the Department the Contractor's fraud, waste, and abuse policy within one hundred twenty (120) days of the execution date of this Contract, and annually thereafter.
iv. Implement regular training to inform staff about fraud, waste, or abuse, the Contractor's policy, and how they can report allegations of fraud, waste, and abuse.
v. Enforce the fraud, waste, and abuse policy and provide ongoing education to its staff regarding their responsibilities.

j. Section IV, I. PCCM Technical Specifications, 6. Technology Documents is revised to add the following:

b. The Contractor shall submit a Vendor Readiness Assessment to the Department for review and approval within ninety (90) Calendar Days after execution of the Contract Amendment, unless otherwise Approved by the Department. The Vendor Readiness Assessment should be updated annually and resubmitted to the Department for review (Link to DHHS template: it.nc.gov/documents/vendor-readiness-assessment-report)

k. Section IV, I. PCCM Technical Specifications, 7. PCCM Data Management is amended to add the following:

h. The Contractor shall submit certification via PCDU concurrently with the submission of data, documentation, or information as specified in 42 C.F.R. 438.604(a). 42 C.F.R. 457.1285; 42 C.F.R. 438.606(c); 42 C.F.R. 438.604(a) - (b)
i. Data, documentation, or information submitted to the state by the Contractor must be certified by one of the following:
1. The Chief Executive Officer (CEO).
2. The Chief Financial Officer (CFO).
3. An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.
ii. The Contractor's certification must attest, based on best information, knowledge, and belief that the data, documentation and information are accurate, complete and truthful.

III. Amendments to Contract Attachments

The following attachments are amended as stated herein.

a. *Attachment A: First Revised and Restated PCCM Fees and Provider Payments* is deleted in its entirety and replaced with the *Attachment A: Second Revised and Restated PCCM Fees and Provider Payments* that is attached to this Amendment and incorporated by this reference.

b. *Attachment B: First Revised and Restated Deliverables and Reporting Requirement* is deleted in its entirety and replaced with the *Attachment B: Second Revised and Restated Deliverables and Reporting Requirements* that is attached to this Amendment and incorporated by this reference.

c. *Attachment C. Managed Care Terminology Provided to PCCM* is deleted in its entirety and replace with the *Attachment C. First Revised and Restated Managed Care Terminology Provided to PCCM* that is attached to this Amendment and incorporated by this reference.

d. *Attachment H.* is revised to reflect Care Management Penetration Rates for FY23 and beyond adjusted for change in population upon Tailored Plan launch.

IV. Effective Date

This Amendment is effective upon the later of the execution dates of the Parties.

V. Unchanged Provisions:

All other terms and conditions of the Contract remain in full force and effect.

VI. Counterparts. This Amendment may be executed in counterparts, each of which shall be deemed an original, but all of which when taken together shall constitute one and the same instrument. Facsimile signatures and signatures transmitted via electronic means (e.g. PDF, DocuSign, etc.) shall be treated as original signatures.

IN WITNESS WHEREOF, the Parties have executed this Amendment in their official capacities as of the dates provided below.

North Carolina Community Care Networks, Inc.

DocuSigned by:
Christopher Woodfin
7ADA05FA6DA3B4B9...
Chris Woodfin, CFO and EVP

Date: 12/13/22 | 10:45 AM EST

North Carolina Department of Health and Human Services,
Division of Health Benefits

DocuSigned by:
Dave Richard
11395D232A054A3...
Dave Richard, Deputy Secretary

Date: 12/13/22 | 7:53 AM PST

Attachment A. Second Revised and Restated PCCM Fees and Provider Payments

1) PCCM Fees Paid to the Contractor

Table 1: Payment to the Contractor (July 2021 until launch of Tailored Care Management)	
Monthly Payment	$3,873,778
InCK Payment	$138,894
Total Enrollment Assumption	418,299
Care Management Population Assumption (Annualized)	109,545

Table 2: Payment to the Contractor (Beginning at launch of Tailored Care Management)	
Monthly Payment	$2,932,692
InCK Payment	$138,894
Total Enrollment Assumption	228,506
Care Management Population Assumption (Annualized)	67,879

2) Payment for Care Management for At Risk Children (CMARC) and Care Management for High-Risk Pregnancy (CMHRP)

Table 3: Payment to the Local Health Departments (LHD)	
Program	PMPM Paid to LHD
CMARC	$4.56
CMHRP	$4.96

3) Primary Care Provider Fees to be Paid by the Department

Table 4: Primary Care Provider Fees to be Paid by the Department	
Provider Type	PMPM Paid to PCP
Carolina Access: Non-ABD and Health Choice	$2.50
Carolina Access: ABD	$5.00
CIHA as of July 1, 2019	$61.65
Carolina Access: Tailored Plan Eligible (upon launch of Tailored Care Management)	$20.00

Attachment B: Second Revised and Restated Deliverables and Reporting Requirements

Second Revised and Restated Table 1: Reports from N3CN					
Report Name	Frequency	Due Date (in Calendar days unless otherwise indicated)	Initial Reporting Period	Initial Due Date	DHB Sign Off Date (in Calendar days unless otherwise indicated)
1. Change in Member Circumstance (MEM009-B)	Monthly	15 days after month end	January 2022	April 15, 2023	30 Days after Received
2. Member Grievance Log	Quarterly	15 days after quarter end	July 1, 2021 to September 30, 2021	October 15, 2021	30 Days after Received
3. Care Needs Screening Report (BCM026)	Quarterly	60 days after the end of the quarter	February – March 2022	May 1, 2022	30 Days after Received
4. Annual Quality Measures Report (QAV007)	Annual	120 days after measurement period (Calendar Year)	Calendar Year 2021	April 30, 2022	30 Days after Received
5. Care Management Interaction Beneficiary Report (BCM051)	Monthly	30 days after the end of the month.	July 2021 August 2021 September 2021 April 2022 will be the first reporting period that includes InCK updates	October 15, 2021 First report with InCK updates is due May 31, 2022	30 Days after Received
6. CCNC Enrolled PCP	Monthly (changes only)	5 business day before the end of the month	July 2021	July 26, 2021	30 Days after Received
7. Cumulative Quarterly Financial Report	Quarterly	45 Calendar Days after the end of the quarter	July 2021 to September 2021	November 15, 2021	30 Days after Received
8. Quality Assurance and Performance	Annual	90 days after contract effective date and	7/1/21 to 6/30/22	9/27/2021	60 days after Received

Second Revised and Restated Table 1: Reports from N3CN					
Report Name	Frequency	Due Date (in Calendar days unless otherwise indicated)	Initial Reporting Period	Initial Due Date	DHB Sign Off Date (in Calendar days unless otherwise indicated)
Improvement Plan (QAPI)		annually thereafter on March 1			
9. Performance Improvement Projects: Quarterly report	Quarterly	30 days after end of quarter	December 2021	1/30/22	30 days after Received
10. N3CN Audited Financial Statement	Annual	December 31	Fiscal Year 2021	December 31, 2021	30 Days after Received
11. State Grant Certification No Overdue Tax Debts	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
12. Federal Certifications & Disclosures	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
13. IRS Tax Exemption Verification Form	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
14. State Certifications	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
15. Conflict of Interest Verification	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
16. COVID-19 Vaccination Enrollee Incentive Program Report	One Time	One-Time, 90-Days after December 31, 2022	July 1 – December 31, 2022	March 31, 2022	30 Days after Received
17. State Data Resource Center (SDRC) Report	Quarterly & Annually	15 days after the Worksheet is sent to CCNC by State	January 2022 to March 2022	April 30, 2022	30 Days after Received

Second Revised and Restated Table 1: Reports from N3CN					
Report Name	Frequency	Due Date (in Calendar days unless otherwise indicated)	Initial Reporting Period	Initial Due Date	DHB Sign Off Date (in Calendar days unless otherwise indicated)
18. Non-Verifiable Member Address and Returned Mail Report (MEM010-B)	Monthly	60 days after month end	January 2023	March 31, 2023	30 Days after Received

Second Revised and Restated Table 2: Deliverables from N3CN	
Deliverable Name	Delivery Time Frame
1. Business Continuity Plan	One hundred twenty-Hundred Twenty (120) days of Contract Execution
2. Care Management Policy	Ninety (90) of Contract Execution and annually thereafter
3. Conflict of Interest Policy	ninety (90) days of Contract Execution
4. Enrollee Grievance Policy	ninety (90) days of Contract Execution
5. Enrollee Handbook	One hundred five days (105) of Contract Execution
6. Enrollee Welcome Letter	Ninety (90) days prior to use with Members and annually thereafter
7. Fraud, Waste and Abuse Policy	One hundred twenty-Hundred Twenty (120) days of Contract Execution
8. Key PCCM Role - Care Management Director	Thirty (30) days of Contract Execution
9. Key PCCM Role - Chief Medical Director	Thirty (30) days of Contract Execution
10. Key PCCM Role - Quality Management Director	Thirty (30) days of Contract Execution
11. Member Educational and Outreach Materials Policy	Sixty (60) of Contract Execution and annually thereafter
12. Provider Participation Agreement	Upon the effective date of the Contract
13. Service Line Operational Prior to Launch.	Ninety (90) of Contract Execution
14. Supplemented Call Scripts	Thirty (30) days prior to use with audience

15. System Security Plan	Ninety (90) days of Contract Execution and annually thereafter
16. System Context Diagram	Ninety (90) days of Contract Execution
17. Summary SOC 2, Type 2	Ninety (90) days of Contract Execution and annually thereafter
18. Vendor Readiness Assessment	Ninety (90) Calendar Days after execution of the Contract Amendment and annually thereafter
19. Whistleblower Policy	One hundred twenty-Hundred Twenty (120) days of Contract Execution
20. Workplace Harassment and Discrimination Policy	Ninety (90) days of Contract Execution

Second Revised and Restated Table 3: Deliverables from DHB	
Deliverable Name	Delivery Time Frame
1. Call Scripts (at least six)	Within thirty (30) days of Contract Execution
2. Enrollee Handbook	Within forty-five (45) days of Contract Execution
3. Approve PCP Participation Agreement	Within thirty (30) days of Contract Execution

Attachment C: First Revised and Restated Managed Care Terminology Provided to PCCM

1. Appeal: The process to seek review of an Adverse Determination for services provided under Medicaid Direct or an Adverse Benefit Determination for services covered under Medicaid Managed Care.
2. Co-Payment: Also known as a "Copay" is a fixed amount paid by the Member for certain covered health care services. The copay amount may vary by service or Provider. Co-pays are not required for IHS eligible individuals. Example: A Member cost of one dollar ($1) for a generic prescription.
3. Durable Medical Equipment (DME): Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is appropriate for home use and is not useful to a person without illness or injury. For devices classified as DME after January 1, 2012, has an expected life of three (3) years.
4. Emergency Medical Condition: A medical condition in which the symptoms appear quickly and are severe enough that a person with average knowledge of health and medicine would expect that, in the absence of immediate medical attention, the health or life of the person experiencing the symptoms is in jeopardy or they are at risk of serious damage to a bodily function, organ, or part.
5. Emergency Medical Transportation: Medically Necessary ambulance transportation to the nearest appropriate facility where prompt medical services are provided in an emergency such as accident, acute illness or injury.
6. Emergency Room Care: Care given for a medical emergency, in a part of the hospital where emergency diagnosis and treatment of illness or injury is provided, when it is believed that one's health is in danger and every second counts.
7. Emergency Services: Inpatient and outpatient services by a qualified Provider needed to evaluate or stabilize an emergency medical condition
8. Excluded Services: Services that are not available under Medicaid FFS.
9. Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested.
10. Habilitation Services and Devices: Health care and support services that help a Member keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services and supports for people with disabilities in a variety of inpatient, outpatient or home and community settings.
11. Health Insurance: A type of insurance coverage that pays for your health and medical costs. Your Medicaid coverage is a type of health insurance.
12. Home Health Care: Certain Medically Necessary services provided to Members in any setting in which normal life activities take place other than a hospital, nursing facility, or intermediate care facility. Services include skilled nursing, physical therapy, speech-language pathology, and occupational therapy, home health aide services, and medical supplies.
13. Hospitalization: Care in a hospital that requires admission as an inpatient for a duration lasting more than twenty-four (24) hours. An overnight stay for observation could be outpatient care.
14. Medically Necessary: Those covered services that are within generally accepted standards of medical care in the community or defined by rule or policy and not typically experimental unless allowed by federal law or rule.

15. PCP Network: A group of Primary Care Providers contracted by the PCCM entity to provide health care services.
16. Non-participating Provider: Non-Par or non-participating Providers are Primary Care Providers that have not entered into an agreement with PCCM entity and are not part of the PCP Network, unlike participating Providers
17. Participating Provider: Par or participating Providers are Primary Care Providers that have an agreement with the PCCM entity and are part of its PCP Network
18. Physician Services: Health care services a licensed medical physician, or physician extender such as a nurse practitioner or physician assistant, provides, orders, or coordinates.
19. Plan: The health Benefit option in which a Member has enrolled.
20. Preauthorization (Prior Authorization): Approval you must have from NC Medicaid before you can get or continue getting certain health care services or medicines.
21. Premium: The amount paid for health insurance monthly. In addition to a premium, other costs for health care, including a deductible, copayments, and coinsurance may also be required.
22. Prescription Drug Coverage: Refers to how Members' prescription drugs and medications are covered under the NC Medicaid and Health Choice State Plan.
23. Prescription Drugs: Also known as prescription medication or prescription medicine, is a pharmaceutical drug that legally requires a medical prescription to be dispensed.
24. Primary Care Physician: A licensed medical doctor (MD) or doctor of osteopathy (DO) that provides and coordinates patient needs and initiates and monitors referrals for specialized services when required. See Primary Care Provider, below.
25. Primary Care Provider (PCP): The participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Member to provide and coordinate the Member's health care needs and to initiate and monitor referrals for specialized services when required. Includes family practitioners, pediatricians, obstetricians, and internal medicine physicians.
26. Provider: Any individual or entity that is engaged in the delivery of health care services, or ordering or referring for those services, and is legally authorized to do so by the state in which services are delivered.
27. Rehabilitation Services and Devices: Health care services and equipment that help keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to sickness, injury, or disablement. These services may include physical and occupational therapy, speech language pathology, and psychiatric rehabilitation services in a variety of inpatient or outpatient settings.
28. Skilled Nursing Care: Care that requires the skill of a licensed nurse.
29. Specialist: A Provider that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
30. Urgent Care: Medical care provided at a walk-in clinic for illnesses or injury that require prompt attention but do not rise to the level of an Emergency Medical Condition.

Attachment H: Program Performance Metrics Reporting Requirements

Table 1: Program Performance Metrics and Targets

A. Care Management Penetration Rates	Annual[1] Target (FY23 before Tailored Care Management Launch)	Annual[1] Target (FY23 and beyond after Tailored Care Management Launch)
1. Overall annual penetration rate Defined as unique members with a completed care management encounter during the contract year.	109,545 members[2]	67,879 members[2]
2. Foster Children receiving complex care management during the year Defined as unique foster care members with a completed care management encounter and care plan during the contract year.	2,402 Foster Care members	4,874 Foster Care members
3. Dual eligible receiving complex care management during the year Defined as unique dual eligible members with a completed care management encounter and care plan during the contract year.	5,064 Dual members	5,210 Dual members

B. **Child Preventive/Primary Care**	**Target (CY23)**
1. Well Child Visits: 0-30 Months of Life (W30)	78.2%
2. Child and Adolescent Well Visits (WCV)	53.2%
3. Childhood Immunization Status: Combination 10 (CIS)	41.7%
4. Immunizations for Adolescents: Combination 2 (IMA)	34%
5. Cervical Cancer Screening (CCS)	48.9%
6. Chlamydia Screening in Women (CHL)	58.5%
7. Controlling High Blood Pressure (CBP)	Observational - No Target
8. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9%) (HPC)	Observational - No Target

9. Plan All Cause Readmissions (PCR) [Observed versus expected ratio]	0.88
10. Total Cost of Care[2]	Observational - No Target

[1] Fiscal Year performance targets will be pro-rated based on annual rates and date of Tailored Care Management launch. For example, if Tailored Care Management launch 12/1/22, FY23 year-end targets will be 85,240 overall penetration rate, 3844 Foster Care members complex care management, 5149 Dual members complex care management.

[2] If total Medicaid Direct population changes by more than 10%, Department and Contractor will mutually agree to adjustment of the overall annual penetration rate target and fixed monthly payment.