

Amendment Number 15 (17)
Contract #30-2020-052-DHB-#

Behavioral Health and Intellectual/ Developmental Disability Tailored Plan

This Amendment (“Amendment”) to the Contract #30-2020-052-DHB-# (“Contract”), as subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits (“Division”), and **Plan Name** (“Contractor” or “BH I/DD Tailored Plan”), each, a Party and collectively, the Parties.

Background:

The purpose of this Amendment is to make clarifications, technical corrections and updates related to the following Sections:

- I. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections; and
- II. Section V. Scope of Services.

The Parties agree as follows:

I. Modifications to Section III. Definitions, Contract Terms, General Terms and Conditions, Other Provisions and Protections

Specific subsections are modified as stated herein.

a. *Section III. Definitions* is revised to add the following newly defined term:

210. **Risk-bearing Subcontractor:** A subcontracted entity that assumes financial risk from the primary managed care plan (MCP).

b. *Section III.B. Acronyms* is revised to add the following:

267. FSPH: Freestanding Psychiatric Hospital

II. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

a. *Section V.B. Medicaid, 3. Care Management, v. Other Care Management Programs, (ii) Local Health Departments, (b)* is revised and restated in its entirety as follows:

(b) Except as to a contract with an LHD that was terminated by the BH I/DD Tailored Plan due to continued underperformance by the LHD in Contract Year 2, the BH I/DD Tailored Plan shall continue to contract through December 31, 2026 with each LHD with which the BH I/DD Tailored Plan contracted in Contract Year 2 pursuant to *Section V.B.3.v.(ii)(a)* of this Contract.

b. *Section V.B. Medicaid, 3. Care Management, v. Other Care Management Programs, (iii) Pregnancy Management Program, (a), (5)* is revised and restated in its entirety as follows:

(5) During Contract Year 1 through December 31, 2026, when a high-risk pregnancy is referred to the BH I/DD Tailored Plan by a PMP provider, member, family or another entity, the BH I/DD Tailored Plan shall be responsible for arranging enrollment of the member into CMHRP and shall inform the member’s PMP provider that the member has entered the program.

c. Section V.B. Medicaid, 4. Providers, v. Provider Payments, (ix) Local Health Department (LHD) Payments, (c) is revised and restated in its entirety as follows:

- (c) For Contract Year 1 through December 31, 2026, the BH I/DD Tailored Plan shall pay in-network LHDs for Care Management for High Risk Pregnant Women services an amount substantially similar to or no less than the amount paid in Medicaid Fee-for-Service prior to BH I/DD Tailored Plan launch (\$4.96 PMPM for all enrolled women, ages fourteen (14) to forty-four (44)).

d. Section V.B. Medicaid, 4. Providers, v. Provider Payments, (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)), (j) is revised to add the following:

- (4) Subsections (1)-(3) of this Section apply to dates of service between July 1, 2024 and June 30, 2025.
- (5) For dates of service between July 1, 2025 and June 30, 2027, the BH I/DD Tailored Plan shall make directed payments to ECU Health Medical Center as follows:
 - (a) The Department will establish a uniform percentage increase for each Medicaid managed care inpatient and outpatient base payment, initially determined by dividing the projected inpatient and outpatient pool amount by the projected Medicaid managed care inpatient base payments.
 - (b) The Department will establish a uniform percentage increase for each Medicaid managed care outpatient base payment, initially determined by dividing the projected outpatient pool amount by the projected Medicaid managed care outpatient base payments.
 - (c) The Department will calculate the directed payment amount to the BH I/DD Tailored Plans on a quarterly basis as the actual Medicaid managed care inpatient and outpatient base payments multiplied by the inpatient and outpatient uniform percentage increase plus the actual total Medicaid managed care outpatient base payments multiplied by the outpatient uniform percentage increase.

e. Section V.B. Medicaid, 4. Providers, v. Provider Payments, (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)), (k) is revised to add the following:

- (4) Subsections (1) - (3) of this section apply to dates of service between July 1, 2024 and June 30, 2025.
- (5) For dates of service between July 1, 2025 and June 30, 2027, the BH I/DD Tailored Plan shall make directed payments to UNC Health Care System hospitals as follows:
 - (a) The Department will establish a uniform percentage increase for each Medicaid managed care inpatient and outpatient base payment, initially determined by dividing the projected inpatient and outpatient pool amount by the projected Medicaid managed care inpatient base payments.
 - (b) The Department will establish a uniform percentage increase for each Medicaid managed care outpatient base payment, initially determined by dividing the projected outpatient pool amount by the projected Medicaid managed care outpatient base payments.
 - (c) The Department will calculate the directed payment amount to the BH I/DD Tailored Plans on a quarterly basis as the actual total Medicaid managed care inpatient and outpatient base payments multiplied by the inpatient and outpatient uniform percentage increase plus the actual total Medicaid managed care outpatient base payments multiplied by the outpatient uniform percentage increase.

f. Section V.B. Medicaid, 4. Providers, v. Provider Payments, (xliv) Healthcare Access and Stabilization Program (HASP) is revised to add the following:

- (b) Freestanding Psychiatric Hospital Component of HASP (July 1, 2025 – June 30, 2026)
 - (1) In accordance with NCGS § 108A-148.1, for dates of service from July 1, 2025 through June 30, 2026, the BH I/DD Tailored Plan shall make payments to eligible in-network Freestanding Psychiatric Hospitals (FSPHs), as defined in NCGS § 108A-145.3(6c), for the FSPH component of HASP calculated by the Department according to the FSPH state directed payment preprint

approved by CMS. The BH I/DD Tailored Plan shall make payments for the FSPH component of HASP as directed by the Department following CMS approval of the FSPH preprint and subject to change by the Department on direction from CMS.

- (c) The requirements specified in *Sections V.B.4.v.(xii)(a)-(g)* and *Section V.B.4.v.(xii)(l)* shall apply to the payments specified in this Section.

g. *Section V.B. Medicaid, 6. Claims and Encounter Management, i. Claims, (v) Overpayment or Underpayment Recovery, (b)* is revised and restated in its entirety as follows:

- (b) In accordance with 42 C.F.R. § 438.608(a)(2), the BH I/DD Tailored Plan, and any Subcontractor delegated responsibility for coverage of services and payment of claims under the Contract by the BH I/DD Tailored Plan, shall report to the Department within thirty (30) Calendar Days each overpayment arising out of fraud, waste, or abuse identified or recovered by the BH I/DD Tailored Plan,. The BH I/DD Tailored Plan shall administer the recovery of overpayments and underpayments in accordance with N.C. Gen. Stat. § 58-3-225(h). Upon identification of overpayments and underpayments, the BH I/DD Tailored Plan shall provide written notice as required under N.C. Gen. Stat. § 58-3-225(h) not less than sixty (60) Calendar Days before the BH I/DD Tailored Plan seeks to recover any overpayments or offsets any future payments from the provider.

h. *Section V.B. Medicaid, 7. Financial Requirements, ii. Medical Loss Ratio, (iv), (b)-(c)* is revised and restated in its entirety as follows:

- (b) At the sole discretion of the Department, the Department may allow the BH I/DD Tailored Plan to contribute some or all of the rebate otherwise to be remitted to the Department to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in *Section V.B.3.x. Healthy Opportunities*; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;
- (c) At the sole discretion of the Department, the Department may allow the BH I/DD Tailored Plan to allocate a portion of the total obligation to be remitted to the Department to a mix of Department approved contributions to health-related resources and/or Department approved public health and Health Equity investments, the remaining portion to a rebate to the Department, with amounts for each BH I/DD Tailored Plan, subject to approval by the Department.

i. *Section V.B. Medicaid, 7. Financial Requirements, ii. Medical Loss Ratio, (ix) Minimum Medical Loss Ratio for Medicaid Expansion Eligible Member Population, (c), (2)-(4)* is revised and restated in its entirety as follows:

- (2) At the sole discretion of the Department, the Department may allow the BH I/DD Tailored Plan to contribute some or all of the rebate otherwise to be remitted to the Department to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in *Section V.B.3.x. Healthy Opportunities*; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;
- (3) At the sole discretion of the Department, the Department may allow the BH I/DD Tailored Plan to allocate a portion of the total obligation to be remitted to the Department to a mix of Department approved contributions to health-related resources and/or Department approved public health and Health Equity investments, the remaining portion to a rebate to the Department, with amounts for each BH I/DD Tailored Plan, subject to approval by the Department.
- (4) At the sole discretion of the Department, the Department may allow the BH I/DD Tailored Plan to allocate a portion of the total obligation to be remitted to the Department to a mix of Department

approved contributions to health-related resources and/or Department approved public health and Health Equity investments and the remaining portion to a rebate to the Department, with amounts for each subject to review and approval by the Department.

j. Section V.B. Medicaid, 7. Financial Requirements, ii. Medical Loss Ratio, (x) Medical Loss Ratio Reporting for Risk-Bearing BH I/DD Tailored Plan Subcontractors is revised to add the following:

- (b) Starting with the rating period beginning on July 1, 2026, and annually thereafter, the BH I/DD Tailored Plan shall require any Risk-bearing Subcontractor who has a reported MLR that is less than the Department-defined minimum MLR for that rating period to remit payment to the BH I/DD Tailored Plan up to the Department-defined MLR.
 - (1) The calculation of the Risk-bearing Subcontractor's MLR for remittance purposes shall be calculated as defined in *Section V.B.7.ii.(x)(a)*.
 - (2) The BH I/DD Tailored Plan shall require its Risk-bearing Subcontractor(s) to pay any remittance owed under *Section V.B.7.ii.(x)(b)(1)* to the BH I/DD Tailored Plan within sixty (60) Calendar Days of the BH I/DD Tailored Plan's receipt of the Subcontractor's MLR report.
 - (3) The BH I/DD Tailored Plan shall report any remittances paid to the BH I/DD Tailored Plan by its Risk-bearing Subcontractor(s) in the BH I/DD Tailored Plan's MLR report template for the applicable rating period according to the instructions to be provided by the Department.

k. Section V.B. Medicaid, 7. Financial Requirements, iii. Financial Management, (vii) Financial Viability, (c)-(d) is revised and restated in its entirety as follows:

- (c) The BH I/DD Tailored Plan shall maintain capital reserves of at least 9.0% of the combined BH I/DD Tailored Plan and PIHP capitation revenue, calculated monthly based on the BH I/DD Tailored Plan's twelve (12) most recent monthly financial reporting template (FRT) submissions.
 - (1) If a BH I/DD Tailored Plan's capital reserves fall below 9.0% of the combined BH I/DD Tailored Plan and PIHP capitation revenue, calculated monthly based on the BH I/DD Tailored Plan's twelve (12) most recent monthly financial reporting template (FRT) submissions, the BH I/DD Tailored Plan must submit a report to the Department that describes the reason for the decline in capital reserves, proposed corrective action to increase capital reserves, and projections of the impact of the corrective actions on the capital reserve levels.
 - (2) If a BH I/DD Tailored Plan's capital reserves fall below 6.25% of the combined BH I/DD Tailored Plan and PIHP capitation revenue, calculated monthly based on the BH I/DD Tailored Plan's twelve (12) most recent monthly financial reporting template (FRT) submissions, the BH I/DD Tailored Plan must submit a report to the Department as described in *Section V.B.7.iii.(vii)(c)(1)* for Department review. The Department reserves the right to stipulate required corrective action for the BH I/DD Tailored Plan.
 - (3) If a BH I/DD Tailored Plan capital reserves fall below 4.0% of the combined BH I/DD Tailored Plan and PIHP capitation revenue, calculated monthly based on the BH I/DD Tailored Plan's twelve (12) most recent monthly financial reporting template (FRT) submissions, the Department reserves the right to place the BH I/DD Tailored Plan under the control of the regulator or initiate actions outlined in *Section VI. Contract Performance for Medicaid and State-funded Services*.
- (d) The Department will determine compliance with the capital reserve percentage, calculated monthly, based on the BH I/DD Tailored Plan's twelve (12) most recent financial reporting template (FRT) submissions, inclusive of both the BH I/DD Tailored Plan and PIHP delivery systems. Medicaid capitation revenue will include monthly PMPM capitation payments, NC Select Drug Case Payments, and maternity event payments, but exclude all other managed

care payments defined in *Section III.D.34. of the Terms and Conditions (i.e. Tailored Care Management payments, monthly single stream allocations, additional directed payments to certain providers, and any Healthy Opportunity Pilot program payments.)*

I. Section V.B. Medicaid, 7. Financial Requirements, v. Risk Corridor for Non-Medicaid Expansion Eligible Member Populations, (i), (a) is revised to add the following:

iii. Period 3: July 1, 2026 to June 30, 2027.

I. Section V.B. Medicaid, 7. Financial Requirements, v. Risk Corridor for Non-Medicaid Expansion Eligible Member Populations, (ii Risk Corridor for Medicaid Expansion Eligible Member Populations, (b), i. is revised to add the following:

3. For Period 3: July 1, 2026 to June 30, 2027.

III. Effective Date

This Amendment is effective July 1, 2026, unless otherwise explicitly stated herein, subject to approval by CMS.

IV. Other Requirements

Unless expressly amended herein, all other terms and conditions of the Contract, as previously amended, shall remain in full force and effect.

Execution:

By signing below, the Parties execute this Amendment in their official capacities and agree to the amended terms and conditions outlined herein as of the Effective Date.

Department of Health and Human Services, Division of Health Benefits

Melanie Bush, Deputy Secretary
NC Medicaid

Date: _____

Plan Name

Plan Signature Authority

Date: _____