Amendment Number 3
Contract #30-2022-007-DHB-X
Medicaid Direct Prepaid Inpatient Health Plan Contract

THIS Amendment to Contract #30-2022-007-DHB-X ("Contract"), is between the North Carolina Department of Health and Human Services ("Department"), Division of Health Benefits ("DHB"), and PIHP Name ("Contractor" or "PIHP"), each, a Party and collectively, the Parties.

Background:

The purpose of this Amendment is to incorporate:

I. Newly defined terms *Section II. Definitions and Abbreviations;* and
II. Requirements in *Section IV. Scope of Services* associated with Medicaid Expansion.

The Parties agree as follows:

I. Modifications to Section II. Definitions and Abbreviations

Specific subsections are modified as stated herein.

a. *Section II. Definitions and Abbreviations, A. Definitions* is revised to add the following newly defined terms:

201. Medicaid Expansion: As defined in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended, which extends Medicaid eligibility to adults under age 65 (including parents and adults without dependent children) with incomes below one hundred thirty-three percent (133%) of the federal poverty level.
202. Medicaid Expansion Eligible Members: NC Medicaid beneficiaries enrolled in Medicaid based on meeting requirements for Medicaid Expansion eligibility category.

II. Modifications to Section IV. Scope of Services

Specific subsections are modified as stated herein.

a. *Section IV.K. Financial Requirements, 2. Medical Loss Ratio* is revised to add the following:

i. Minimum Medical Loss Ratio for Medicaid Expansion Eligible Member Population
   i. PIHP shall calculate and report a distinct aggregate Department-defined MLR for Medicaid Expansion Eligible Member population on an annual basis aligned to the rating period (from the start of Medicaid Expansion through June 30, 2024).
      1. The numerator, denominator, and MLR calculations for the Department-defined MLR, including exclusions, will be consistent with those defined in *Section IV.K.2.b.* and *Section IV.K.2.c.i.-ii.* of the Contract.
      2. PIHP shall provide explanations for any allocation methods required to split expenditures between Medicaid Expansion Eligible Member populations and non-Medicaid Expansion populations on the Department's defined MLR templates.
      3. PIHP shall aggregate data for Medicaid Expansion Eligible Member populations covered under the Contract for purposes of calculating the Department-defined MLR.

4. PIHP shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 member months in a MLR reporting period.
5. All Tailored Care Management revenue received outside of capitation shall be excluded from the denominator of both the CMS-defined MLR and Department-defined MLR.
6. PIHP shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by Department.
7. Care Coordination expenses included in the numerator of the MLR shall not exceed the combined expenditures for Care Coordination and Tailored Care Management less Tailored Care Management revenue received outside of capitation.

ii. The CMS-defined MLR will be reported in aggregate combined for the Medicaid Expansion Eligible Member and non-Medicaid Expansion populations as defined in *Section IV.K.2.b.i.* of the Contract.

iii. If PIHP's Department-defined MLR is less than the minimum MLR threshold, PIHP shall do one (1) of the following:
1. Remit to Department a rebate equal to the denominator of Department-defined MLR, multiplied by the difference between the minimum MLR threshold and Department defined MLR;
2. Allocate a portion of the total obligation to a mix of Department-approved contributions to health-related resources, the remaining portion to a rebate to Department, with amounts for each PIHP subject to review and approval by Department; or
3. Contribute to initiatives that advance public health and Health Equity in alignment with Department's Quality Strategy, subject to approval by Department.

iv. The minimum MLR threshold for PIHP shall be eighty-five percent (85%).

v. PIHP must attest to the accuracy of the calculation of the Department-defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports in accordance with 42 C.F.R. § 438.8(n).

vi. PIHP shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to PIHP within one hundred eighty (180) Calendar Days of the end of the MLR reporting year or within thirty (30) Calendar Days of being requested by PIHP, whichever comes sooner to calculate and validate the accuracy of MLR reporting in accordance with 42 C.F.R. § 438.8(k)(3).

vii. In any instance where Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to Department, PIHP shall:
1. Re-calculate the MLR for all MLR reporting years affected by the change, and
2. Submit a new MLR report meeting the applicable requirements in accordance with 42 C.F.R. § 438.8(m); 42 C.F.R. § 438.8(k).

viii. The final minimum Medicaid Expansion Eligible Member MLR arrangement shall be settled after the final risk corridor determination for the Medicaid Expansion Eligible Member population.

b. Section IV.K. Financial Requirements, 4. Risk Corridor is revised to add the following:

l. Risk Corridor for Medicaid Expansion Eligible Member Population

i. A risk corridor arrangement between PIHP and Department will apply to share in gains and losses of PIHP for Medicaid Expansion Eligible Member populations as defined in this Section. The Risk Corridor payments to and recoupments from PIHP will be based on a comparison of PIHP's reported Risk Corridor Treatment Ratio ("Reported Treatment Ratio") for the Risk Corridor Measurement Period as defined in this Section, to the Target Treatment Ratio consistent with capitation rate setting and set forth in *Section VII. Medicaid PIHP Rate Book* ("Target Treatment Ratio").

ii. The risk corridor parameters for Medicaid Expansion Eligible Member population shall be consistent with those defined for the non-Medicaid Expansion population in *Section IV.K.4.c.-i.* of the Contract. Determination of payments and recoupments for Medicaid Expansion Eligible Member populations shall be calculated separately from the non-Medicaid Expansion population.

1. The Risk Corridor Measurement Period is defined as the start of Medicaid Expansion to June 30, 2024.
2. The numerator and denominator calculations for the Target Treatment Ratio and Reported Treatment Ratio, including exclusions, will be consistent with those defined in *Section IV.K.4.e.-g.* of the Contract.
3. The risk corridor payments and recoupments will be based on a comparison of PIHP's Reported Treatment Ratio for the measurement period to a Target Treatment Ratio derived from capitation rate-setting by Department. The Target Treatment Ratio will be documented in *Section VII. Medicaid PIHP Rate Book* by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.
4. The PIHP Target Treatment Ratio for Medicaid Expansion Eligible Member populations shall be calculated using the Target Treatment Ratio for each applicable rate cell documented in *Section VII. Medicaid PIHP Rate Book* and weighted by PIHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based payments and Tailored Care Management payments outside of monthly capitation).

iii. The PIHP shall calculate the numerator and denominator terms of the Reported Treatment Ratio based on actual experience for the Risk Corridor Measurement Period and report them to the Department in a format prescribed by the Department.

iv. The PIHP shall provide an attestation of the accuracy of the information provided in its submitted risk corridor calculations, as specified in 42 C.F.R. § 438.606.

v. Terms of the Risk Corridor

1. If the Reported Treatment Ratio is less than the Target Treatment Ratio minus three percent (3%), PIHP shall pay Department eighty percent (80%) of the Reported Treatment Ratio denominator multiplied by the difference between the Target Treatment Ratio minus three percent (3%) and the Reported Treatment Ratio.
2. If the Reported Treatment Ratio is greater than the Target Treatment Ratio plus three percent (3%), Department shall pay PIHP eighty percent (80%) of the

Reported Treatment Ratio denominator multiplied by the difference of the Reported Treatment Ratio and the Target Treatment Ratio plus three percent (3%).

vi. Risk Corridor Settlement and Payments

1. Department will complete a settlement determination for the Risk Corridor Measurement Period.
2. PIHP shall provide the Department with an interim Risk Corridor Treatment Ratio report on a timeline and in a format prescribed by Department.
3. PIHP shall provide the Department with a final Risk Corridor Treatment Ratio report on a timeline and in a format prescribed by the Department.
4. PIHP shall provide explanations for any allocation methods required to split expenditures between Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.
5. PIHP shall provide additional information and documentation at the request of Department to support the Risk Corridor Settlement determination.
6. Department may choose to review or audit any information submitted by PIHP.
7. Department will complete a Risk Corridor Settlement determination for the Risk Corridor Measurement Period. In preparing the settlement, Department will make final decisions about covered costs included in the settlement.
8. Department will provide PIHP with written notification and corresponding documentation of the final Risk Corridor Settlement determination prior to initiating a payment or remittance. The risk corridor settlement shall become final if dispute resolution is not requested pursuant to *Section V. Contract Performance* within thirty (30) Calendar Days of the notice by Department to PIHP.
9. If the final Risk Corridor Settlement requires PIHP to remit funds to Department, the PIHP must submit any undisputed remittance to Department within ninety (90) Calendar Days of the date of Department's notification of the final Risk Corridor settlement. If PIHP initiates a dispute as described in *Section V. Contract Performance* the deadline for PIHP to submit remittance to Department shall be stayed pending the outcome of the dispute.
10. At the sole discretion of Department, Department may allow PIHP to contribute all or a part of the amount otherwise to be remitted to:
    a. Contributions to health-related resources targeted towards high-impact initiatives that align with Department's Quality Strategy that have been reviewed and approved by the Department.
    b. Contribute to initiatives that advance Health Equity in alignment with the Department's Quality Strategy that have been reviewed and approved by Department.
11. To be considered for the in lieu of remittance option as described in *Section IV.K.4.l.vi.10*, PIHP must submit a proposal to Department for review and approval concurrent with or prior to submission of PIHP's interim Risk Corridor Treatment Ratio report.
12. If PIHP has not made a required remittance payment within the final date required by this Section, Department may choose to recover any obligation due from PIHP

by offsetting a subsequent monthly capitation payment. For avoidance of doubt, a disputed remittance payment will not be considered required until such dispute is resolved in accordance with *Section V. Contract Performance*.

13. If the final Risk Corridor Settlement requires Department to make additional payment to PIHP, Department shall initiate payment within ninety (90) Calendar Days after Department's notification of the final Risk Corridor settlement. If PIHP initiates a dispute as described in *Section V. Contract Performance* the deadline for Department to make the additional required payments shall be stayed pending the outcome of the dispute.
14. The Medicaid Expansion Eligible Member population risk corridor shall be settled in advance of the final minimum Medicaid Expansion MLR reporting and determination.

III. Effective Date

This Amendment is effective October 1, 2023, 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

_____ Date: _____

Jay Ludlam, Deputy Secretary
NC Medicaid

Plan Name

_____ Date: _____

Plan Signature Authority