

AMENDMENT NUMBER 8

**CONTRACT #30-2024-001-DHB
CHILDREN AND FAMILIES SPECIALITY PLAN**

BETWEEN

THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS

AND

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

THIS Amendment to Contract #30-2024-001-DHB (“Contract”), which was made effective August 15, 2024 and subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits (“Department”), and Blue Cross and Blue Shield of North Carolina (“Contractor”). Department and Contractor may be individually referred to as “Party” and collectively as the “Parties.”

Background

The Children and Families Specialty Plan (“CFSP”) is an integrated Medicaid Managed Care plan that covers services specified to address a spectrum of Member needs, including those related to physical health, behavioral Health, I/DD, LTSS, and pharmacy services and unmet health-related resource needs. Intended to meet the unique health care needs of children, youth and families currently and formerly served by the child welfare system, the CFSP operates statewide, enabling Members to access a broad range of physical health and behavioral health services and maintain treatment plans when their geographic locations change.

The purpose of this Amendment is to make updates related to financial-related provisions including risk mitigation strategies, State Directed Payments and other provider payments, and overpayment and underpayment recoveries in the following Sections of the Contract as follows:

1. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions & Protections; and
2. Section V. Scope of Services.

The Parties agree as follows:

1. Modifications to Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions & Protections

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

244. ACR: Average Commercial Rate
245. HASP: Healthcare Access and Stabilization Program

2. Modifications to Section V. Scope of Services

Specific subsections of the Contract are revised as follows:

- a. Section V.E. Providers, 4. Provider Payments, I. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)) is revised to add the following additional requirements:***

- xiii. For Directed Payments to East Carolina University (ECU) Health Medical Center:
- 1) Subsections a) through c) of this Section apply to dates of service between July 1, 2026, and June 30, 2027:
 - 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 CFSP 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 base payments multiplied by the outpatient uniform percentage increase.

b. Section V.E. Providers, 4. Provider Payments, I. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)) is revised to add the following additional requirements:

- xiv. For Directed Payments to University of North Carolina Health Care System Hospitals:
- 1) Subsections a) through c) of this Section apply to dates of service between July 1, 2026 and June 30, 2027:
 - 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 CFSP 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 base payments multiplied by the outpatient uniform percentage increase.

c. Section V.E. Providers, 4. Provider Payments, is revised to add the following additional requirements:

- gg. Healthcare Access and Stabilization Program (HASP):
- i. NCGS § 108A-148.1 requires the Department to submit an annual 42 C.F.R. § 438.6(c) Preprint for the Healthcare Access and Stabilization Program (HASP) for approval by CMS. Under HASP, eligible hospitals will receive payments from the CFSP up to the average commercial rate (ACR) for all inpatient and outpatient hospital services, as specified in this Section and approved by CMS. The CFSP shall make HASP payments as directed by the Department following approval of the HASP preprint for the applicable time period by CMS and subject to change by the Department based on direction from CMS.

d. Section V.E. Providers, 4. Provider Payments, p. Payment of Medical Home Fees to AMH, iii. is revised and restated in its entirety as follows:

- iii. The CFSP may pay Performance Incentive Payments to AMH practices, subject to the following requirements:
 - 1) The CFSP shall design Performance Incentive Payments to be in addition to Enhanced Medical Home Fees (i.e., the CFSP shall not place all or part of the Enhanced Medical Home Fees at risk based on performance);
 - 2) The CFSP shall use the HCP LAN Levels 2 through 4 as a framework for the design of the Performance Incentive Payments for AMHs; and
 - 1) The CFSP shall exclusively base the calculation of all Performance Incentive Payments on the defined AMH quality measure set.
- e. **Section V.F. Quality and Value, 2. Value-Based Payments/Alternative Payment Models, a. is revised and restated in its entirety as follows:**
 - a. To advance the Department’s vision for quality and to ensure that payments to providers are increasingly focused on population health, integration of physical and BH, appropriateness of care and other measures related to value included in the CFSP Quality Strategy, the Department encourages the adoption of VBP arrangements between the CFSP and providers. The Department will issue additional guidance and details on VBP recommendations for the CFSP.
- f. **Section V.I. Claims and Encounter Management, 1. Claims, f. Overpayment or Underpayment Recovery, ii. is revised and restated in its entirety as follows:**
 - ii. In accordance with 42 C.F.R. § 438.608(a)(2), the CFSP and any Subcontractor that is delegated responsibility by the CFSP for coverage of services and payment of claims under the Contract shall report to the Department within thirty (30) Calendar Days each overpayment identified or recovered by the CFSP. The CFSP shall administer the recovery of overpayments and underpayments in accordance with NCGS § 58-3-225(h). Upon identification of overpayments and underpayments, the CFSP shall provide written notice as required under NCGS § 58-3-225(h) not less than sixty (60) Calendar Days before the CFSP seeks to recover any overpayments or offsets any future payments from the provider.
- g. **Section V.J. Financial Requirements, 2. Medical Loss Ratio, d. is revised and restated in its entirety as follows:**
 - d. If the CFSP’s Department-defined MLR is less than the minimum MLR threshold, the CFSP shall do one of the following:
 - i. Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;
 - ii. At the sole discretion of the Department, the Department may allow the CFSP 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.D.9. Healthy Opportunities*; a proposal for contributions must align with the Department’s Quality Strategy and be reviewed and approved by the Department;
 - iii. Reserved; and
 - iv. At the sole discretion of the Department, the Department may allow the CFSP 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 subject to review and approval by the Department.

h. Section V.J. Financial Requirements, 2. Medical Loss Ratio, i. is revised and restated in its entirety as follows:

- i. Medical Loss Ratio Reporting for Risk-bearing Subcontractors
 - i. Starting January 1, 2026, the CFSP shall require any risk-bearing Subcontractors, as defined by the Department, to calculate and report the CMS-defined MLR experienced in an MLR reporting year as defined in 42 C.F.R. § 438.8. The first MLR reporting year for vendors will be January 1, 2026 – June 30, 2026 and aligned with the CFSP’s rating period thereafter.
 - 1) The CFSP shall require Subcontractors to calculate and report MLR consistent with the Department requirements in 42 C.F.R. § 438.8(c) and 438.8(k) on an aggregate basis combining experience for Medicaid Expansion Eligible Members and non-Medicaid Expansion populations.
 - 2) The CFSP’s Subcontractor(s) shall apply a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3) using the CMS published credibility factors.
 - 3) The CFSP’s Subcontractor(s)’s report shall be submitted to the CFSP within one hundred eighty (180) Calendar Days of the end of the MLR reporting year.
 - 4) The CFSP may require that all classification of activities that improve health care quality, including contributions to health-related resources and initiatives that advance public health and Health Equity be submitted to the CFSP for review and approval. Any activities approved by the CFSP shall be submitted to the Department for review and approval prior to the Subcontractor’s inclusion of the activities in the calculation of its MLR. All activities that the CFSP requests to include in the CFSP’s MLR calculations must be submitted to the Department.
 - 5) The CFSP shall report the outcome of Subcontractor MLR calculations in the MLR templates and associated instructions to be provided by the Department.
 - ii. Starting with the rating period beginning on July 1, 2026, and annually thereafter, the CFSP 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 CFSP up to the Department defined MLR.
 - 1) The calculation of the risk-bearing Subcontractor(s) MLR for remittance purposes shall be the same as defined in *Section V.J.2.i*.
 - 2) The CFSP shall require its risk-bearing Subcontractor(s) to pay any remittance owed under *Section V.J.2.i.ii.1*) to the CFSP within sixty (60) Calendar Days of the CFSP’s receipt of the Subcontractor MLR report.
 - 3) The CFSP shall report any remittances paid to the CFSP by any risk-bearing Subcontractor in the CFSP’s MLR report template for the applicable rating period according to the instructions to be provided by the Department.
 - iii. Reserved.
 - iv. Reserved.
 - v. Reserved.

i. Section V.J. Financial Requirements, 2. Medical Loss Ratio, j. Risk Corridor, i. is revised and restated in its entirety as follows:

- i. For the purposes of this subsection, the Risk Corridor Measurement Period is defined as:

1) For Period 1, December 1, 2025 – June 30, 2026

j. Section V.J. Financial Requirements is revised to add additional requirements as following:

4. Risk Corridor

Except as to the Risk Corridor Measurement for the Period of December 1, 2025- June 30, 2026, which is described in *Section V.J.2.j.*, the risk corridor arrangement between the CFSP and the Department will apply to share in gains and losses of the CFSP populations as defined in this section. The Risk Corridor payments to and recoupments from the CFSP will be based on a comparison of the CFSP's reported Risk Corridor Services Ratio ("Reported Services Ratio") for the Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in the CFSP Rate Book ("Target Services Ratio").

- a. For the purposes of this *Section V.J.4.*, the Risk Corridor Measurement Period is defined as:
 - i. For Period 2, July 1, 2026 – June 30, 2027.
- b. For Period 2, the risk corridor shall be calculated in aggregate across Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.
- c. The risk corridor payments and recoupments will be based on a comparison of the CFSP's Reported Services Ratio for the measurement period to a Target Services Ratio derived from capitation rate-setting by the Department. The Target Services Ratio will be documented in the CFSP Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.
- d. The CFSP Target Services Ratio shall be calculated using the Target Services Ratio for each rate cell documented in the CFSP Rate Book and weighted by the CFSP's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based and/or wrap payments).
- e. The Reported Services Ratio numerator shall be the CFSP's expenses for the Risk Corridor Measurement Period specific to the North Carolina Medicaid managed care program. The numerator shall be defined as the sum of:
 - i. Incurred claims as defined in 42 C.F.R. 438.8(e)(2)(i)-438.8(e)(2)(iii) for State Plan Services, approved In-Lieu of Services, and approved Value-Added Services not including additional utilization-based directed payments or wrap payments.
 - ii. Advanced Medical Home Fees as defined in *Section V.E.4. Provider Payments* including any uniform increases across all eligible providers above the defined floor and other increases with written approval from the Department.
 - iii. Performance Incentive Payments to Advanced Medical Homes as defined in *Section V.E.4. Provider Payments*.
 - iv. Other quality-related incentive payments to NC Medicaid providers.
 - v. Non-claims-based provider stabilization payments to support provider sustainability and beneficiary access.
 - vi. Contributions to community-based health-related resources and initiatives that advance public health and Health Equity, subject to Department review and approval.
- f. The CFSP is prohibited from including in the Reported Services Ratio numerator the following expenditures:
 - i. Payments to providers for delegated Care Management.
 - ii. Advanced Medical Home Fees above the defined floor that are not uniform across all providers and have not received written approval for inclusion by the Department.
 - iii. Interest or penalty payments to providers for failure to meet prompt payment standards.
 - iv. Payments to related providers that violate the Payment Limitations as required in the Contract.
 - v. Additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) or other wrap payments, that are reimbursed by the

- Department separate from the prospective PMPM capitation, NC Select Drug Case Payments and maternity event payments.
- vi. Voluntary contributions to health-related resources or initiatives that advance public health and Health Equity made in lieu of rebates paid to the Department if the CFSP's Department-defined MLR is less than the minimum MLR threshold for a prior year as described in *Sections V.J.2.d.* of this Contract.
 - vii. Voluntary contributions to health-related resources or initiatives that advance public health and Health Equity made in lieu of remittances paid to the Department if the CFSP's risk corridor measurement resulted in a payment to the Department for a prior year as described in *Sections V.J.2.j.xi.9)* of this Contract.
 - g. The Reported Services Ratio denominator represents the Medicaid managed care capitation revenue received by the CFSP for enrollments effective during the Risk Corridor Measurement Period. The denominator shall be equal to the Department-defined MLR denominator.
 - h. CFSP shall calculate the numerator and denominator terms of the Reported Services Ratio based on actual experience for the Risk Corridor Measurement Period and report them to the Department in a format prescribed by the Department.
 - i. The CFSP must 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.
 - j. Terms of the Risk Corridor
 - i. If the Reported Services Ratio is less than the Target Services Ratio minus three percent (3%), the CFSP shall pay the Department eighty percent (80%) of the Reported Services Ratio denominator multiplied by the difference between the Target Services Ratio minus three percent (3%) and the Reported Services Ratio.
 - ii. If the Reported Services Ratio is greater than the Target Services Ratio plus three percent (3%), the Department shall pay the CFSP eight percent (80%) of the Reported Services Ratio denominator multiplied by the difference of the Reported Services Ratio and the Target Services Ratio plus three percent (3%).
 - k. Risk Corridor Settlement and Payments
 - i. The Department will complete a settlement determination for the Risk Corridor Measurement Period.
 - ii. The CFSP shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
 - iii. The CFSP shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
 - iv. The CFSP shall provide additional information and documentation at the request of the Department to support the Risk Corridor Settlement determination.
 - v. The Department may choose to review or audit any information submitted by the CFSP.
 - vi. The Department will complete a Risk Corridor Settlement determination for the Risk Corridor Measurement Period. In preparing the settlement, the Department will make final decisions about covered costs included in the settlement.
 - vii. The Department will provide the CFSP 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 VI. G. Dispute Resolution.*
 - viii. If the final Risk Corridor Settlement requires the CFSP to remit funds to the Department, the CFSP must submit remittance to the Department within ninety (90) Calendar Days of the date of the Department's notification of the final Risk Corridor settlement.
 - ix. At the sole discretion of the Department, the Department may allow the CFSP to contribute all or a part of the amount otherwise to be remitted to:
 - 1) Contributions to health-related resources targeted towards high-impact initiatives that align with the Department's Quality Strategy that have been reviewed and approved by the Department.

- 2) Contribute to initiatives that advance public health and Health Equity in alignment with the Department’s Quality Strategy that have been reviewed and approved by the Department.
- x. To be considered for the in lieu of remittance option, the CFSP must submit a proposal to the Department for review and approval concurrent with or prior to submission of the CFSP’s interim Risk Corridor Services Ratio report.
- xi. If the CFSP has not made the required remittance payment within the final date required by this Section, the Department may choose to recover any obligation due from the CFSP by offsetting a subsequent monthly capitation payment.
- xii. If the final Risk Corridor Settlement requires the Department to make additional payment to the CFSP, the Department shall initiate payment within ninety (90) Calendar Days after the Department’s notification of the final Risk Corridor settlement. If the CFSP initiates a dispute as described in accordance with *Section VI. G. Dispute Resolution*, the deadline for the Department to make the additional required payments shall be stayed pending the outcome of the dispute.

c. **Effective Date:** This Amendment is effective July 1, 2026, unless otherwise explicitly stated herein, subject to approval by CMS.

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

IN WITNESS WHEREOF, the Parties have executed this Amendment in their official capacities as of the Effective Date.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

Angela Boykin, Chief Executive Officer (CEO)

Date: _____

THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS

Melanie Bush, Deputy Secretary
NC Medicaid

Date: _____