Amendment Number 25 (26)
Prepaid Health Plan Services
#30-190029-DHB – PHP Name

This Amendment to the Prepaid Health Plan Services Contract #30-190029-DHB – PHP Name (Contract) awarded February 4, 2019, and subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and PHP Name (Contractor), each, a Party and collectively, the Parties.

Background:
The purpose of this Amendment is to incorporate new requirements related to reimbursement and reporting for NC Select Drugs and clarify requirements related to the risk mitigation provisions of the Contract for the rating period beginning on July 1, 2025. Changes to the following Sections of the Revised and Restated Request for Proposal #30-190029-DHB are being made:

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

The Parties agree as follows:

I. <u>Modifications to Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections</u>

Specific subsections are modified as stated herein.

a. *Section III. A. Definitions* is revised to add the following:

184. **NC Select Drug:** A drug that meets the definition of a covered outpatient drug, as defined in 42 C.F.R. § 447.502, and has been listed on the NC Select Drug List by the Department.
185. **NC Select Drug List:** A list of drugs maintained by the Department and made available on its public-facing website that include but are not limited to Cell and Gene Therapies which meet the definition of a covered outpatient drug, as defined in 42 C.F.R. § 447.502, that are covered under the NC Medicaid Benefit that are carved out of the inpatient diagnosis-related group or outpatient ratio of cost to charges and claimed separately to allow the capture of rebates.

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

217. AAC: Actual Acquisition Cost
218. ASP: Average Sales Price
219. DRG: Diagnosis-Related Group
220. RCC: Ratio of Cost to Charges

c. *Section III., D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT:, a., ii.,* is revised and restated in its entirety as follows:

ii. Maternity event payments and NC Select Drug Case payments;

d. *Section III. D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT:, c. Maternity Event Payments,* is revised and restated in its entirety as follows:

c. **Maternity Event Payments and NC Select Drug Case Payments:**

i. As provided in *Section V.I.1. Financial Requirements*, the Contractor will be eligible to receive a separate maternity event payment. Payment will be made after the Contractor submits required documentation of an eligible delivery event to the Department. The Contractor must

accept maternity event capitation rates developed by the Department and its actuary and approved by CMS.

ii. As provided in *Section V.I.1. Financial Requirements*, the Contractor will be eligible to receive a separate NC Select Drug Case payment, as applicable. Payment will be made after the Contractor submits required documentation of paid claims in the NC Select Drug Report and the encounter being accepted by the Department. The Contractor must accept the NC Select Drug Case payment rates developed by the Department and its actuary and approved by CMS.

II. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

a. ***Section V. A. Administration and Management, 1. Program Administration, h. Compliance with Department Policies, i., p),*** **is revised and restated as follows*:***

p) North Carolina Medicaid Transformation Clinical Supplemental Guidance;

b. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered services:, v.,*** **is revised and restated in its entirety as follows:**

v. The PHP shall adhere to the Department's North Carolina Medicaid Transformation Clinical Supplemental Guidance, which references requirement for clinical coverage which supplement NC Medicaid clinical coverage policies.

c. ***Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package*** **is revised to add the following:**

o. NC Select Drugs Notification and Reporting

i. The PHP shall notify the Department within fourteen (14) Calendar Days in accordance with the notification process outlined in the *North Carolina Medicaid Transformation Clinical Supplemental Guidance* when any of the following occurs:

a) A provider requests prior approval for an NC Select Drug, which requires prior approval from the PHP.

1. The notification by the PHP shall include the Member identification number, Provider, drug name, and anticipated infusion date (if known).

b) A claim is received by the PHP for an NC Select Drug.

1. The notification by the PHP shall include the Member identification number, provider, drug name, infusion date, and claim received date.

c) A claim is paid by the PHP for an NC Select Drug.

1. The notification by the PHP shall include the Member identification number, Provider, drug name, and claim payment date.

ii. To support Department reporting to CMS related to NC Select Drug usage, the PHP shall submit the NC Select Drug Report as described in *Attachment J: Tenth Revised and Restated Reporting Requirements*.

d. ***Section V. C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, ii. Ingredient Costs, j) Medical Professional Drug Claims,*** **is revised and restated as follows with no revisions to subparts 1.-4.:**

j) Medical Institutional and Professional Drug Claims

e. ***Section V. C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, ii. Ingredient Costs, j) Medical Professional Drug Claims,*** **is revised to add the following:**

5. NC Select Drug List

i. Drugs on the NC Select Drug List, including but not limited to Cell and Gene Therapies (CGTs), which meet the definition of a covered outpatient drug, as defined in 42 C.F.R. § 447.502, are covered under the NC Medicaid Benefit.
   a. The NC Select Drug List maintained by the Department can be found by the PHP here: https://medicaid.ncdhhs.gov/providers/pharmacy-services.
   b. The Department may modify the NC Select Drug List for the inclusion or exclusion of additional drugs.
   c. The PHP shall reimburse drugs added to the NC Select Drug List according to the reimbursement logic provided in this Section within forty-five (45) Calendar Days of notification from the Department that the NC Select Drug List has been modified.

ii. Drugs administered in an inpatient hospital setting shall be reimbursed by the PHP based on the ingredient component of the NC Select Drug at the Actual Acquisition Cost (AAC) net of all costs such as rebates and discounts, received by the hospital.

iii. Drugs administered in an outpatient hospital setting shall be reimbursed by the PHP based on the ingredient component of the NC Select Drug at the lesser of the Actual Acquisition Cost (AAC) or Average Sales Price (ASP) net of all costs such as rebates or discounts received by the hospital.

iv. Drugs administered in a professional outpatient setting shall be reimbursed by the PHP based on the ingredient component of the NC Select Drug at the lesser of the Actual Acquisition Cost (AAC) or the Average Sales Price (ASP) net of all costs such as rebates or discounts received by the provider.

v. If the PHP enters a single case agreement with a non-participating provider related to NC Select Drugs, the PHP shall ensure that the NC Select Drugs are reimbursed in accordance with the reimbursement methodology described in this Section.

vi. NC Select Drugs administered in any setting shall be reimbursed directly to the rendering provider eligible to perform the infusion.
   a. The PHP shall not reimburse point of sale pharmacies, including specialty pharmacies, directly for NC Select Drugs.

vii. For inpatient and outpatient services related to administration of NC Select Drugs, the PHP shall require providers to bill NC Select Drugs separate from services reimbursed based on Diagnosis-Related Group (DRG) or Ratio of Cost to Charge (RCC) rate methodologies. The PHP shall require claims for NC Select Drugs to be billed by providers with both the HCPCS and NDC listed.

viii. The PHP shall require providers to submit the actual invoice, which reflects the actual acquisition cost paid by the provider or hospital net of any rebates or discounts received by the hospital or provider, to demonstrate the actual drug acquisition cost paid. The PHP shall ensure that bona fide service fees, meeting the federal definition in 42 C.F.R. § 423.501, are not required to be reported as cost offsets by the provider. Bona fide service fees would be allowable under the federal definition of a service fee.
   a. For NC Select Drugs administered in an hospital inpatient, hospital outpatient, or professional outpatient setting, the provider's Chief Executive Officer, Chief Financial Officer, or appropriate designee responsible for billing is required to attest that the net invoice cost reflects the actual costs incurred by the provider for the drug, to include all cost offsets such as rebates received by the provider, or discounts. The provider's designee can attest to the validity of the invoice cost by signing the submitted invoice, including their printed name and title.

ix. The PHP shall not reimburse providers using 340B inventory for drugs on the NC Select Drug List furnished to Members.

x. The reimbursement methodology described in this Section for drugs on the NC Select Drug List is effective for claims reimbursed by the PHP for dates of services on or after January 1, 2025.

f. ***Section V. I. Financial Requirements, 1. Capitation Payments, a.,* is revised and restated in its entirety as follows:**

a. Capitation rates will be set by the Department and developed in an actuarially sound manner, reflecting the contractual requirements and expectations of PHPs. Capitation payments include risk-adjusted Monthly Per Member Per Month payments, maternity event payments, NC Select Drug Case Payments, and payments for additional directed payments to certain providers as required under the Contract. This solicitation includes the Draft Rate Book which is intended to include sufficient information to support entities in making business decisions related to responding to the RFP. Final rates will reflect the more recent historical experience and changes to program requirements not reflected in the Draft Rate Book.

g. ***Section V. I. Financial Requirements, 1. Capitation Payments, h.,* is revised and restated in its entirety as follows:**

h. The Department will reimburse PHP for additional directed payments to providers as required under *Section V. D. 4. Provider Payments (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*. The PHP is required to make these payments to certain providers but the payments are explicitly excluded from the prospective PMPM, maternity event and NC Select Drug Case capitation payments. The PHP shall provide the necessary data to support this process in a format and frequency to be defined by the Department.

h. ***Section V. I. Financial Requirements, 1. Capitation Payments, i.,* is revised and restated in its entirety as follows:**

i. The Department has established a separate NC Select Drug Case payment for certain drugs on the NC Select Drug List, as indicated on the applicable rate sheet in *SECTION X. SUMMARY OF CONTRACTUAL PAYMENT AND RISK SHARING TERMS,* as amended. This payment will be made to the PHP based on NC Select Drugs reported as paid claims in the NC Select Drug Report as defined in *Attachment J: Tenth Revised and Restated Reporting Requirements* and the corresponding encounter being accepted by the Department through the Encounter Processing System.

j. The Department will make capitation payments in accordance with the Payment and Reimbursement term in *Section III. D. 32.* ***PAYMENT AND REIMBURSEMENT***.

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

i. The PHP shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8. The CMS-defined MLR shall be reported in aggregate combined for Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.

j. ***Section V. I. Financial Requirements, 2 Medical Loss Ratio, b., iv., a), 2., i.,* is revised and restated in its entirety as follows:**

i. Required 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, maternity event payments, and NC Select Drug Case payments.

k. ***Section V. I. Financial Requirements, 4. Risk Corridor, a., i.,* is revised to add the following:**

e) For rating year five as July 1, 2025 to June 30, 2026.

l. ***Section V. I. Financial Requirements, 4. Risk Corridor, a., vi., f),*** **is revised and restated in its entirety as follows:**

f) 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.

m. ***Section V. I. Financial Requirements, 4. Risk Corridor, b. Risk Corridor for Medicaid Expansion Eligible Member Populations, ii., a),*** **is revised to add the following:**

iii. For Period 3: July 1, 2025 to June 30, 2026.

n. ***Section V. I. Financial Requirements, 5. Minimum Primary Care Provider (PCP) Expenditure Requirement, e., iii.,*** **is revised and restated in its entirety as follows:**

iii. For the Risk Corridor Measurement Period for rating years three, four, and five: ninety-five percent (95%) of the PCP Target Expenditure Percentage for each rate cell documented in the Standard Plan Rate Book and weighted by the PHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization based payments).

III. Modifications to Section VII. Attachments

Specific Attachments are modified as stated herein.

a. ***Attachment J. Ninth Revised and Restated Reporting Requirements is revised and restated in its entirety as Attachment J. Tenth Revised and Restated Reporting Requirements and attached to this Amendment.***

IV. Effective Date

Amendment is effective July 1, 2025, unless otherwise explicitly stated herein, subject to approval by CMS.

V. 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

__________________________________ Date: ________________________

Jay Ludlam, Deputy Secretary
NC Medicaid

Plan Name

__________________________________ Date: ________________________

Plan Signature Authority

Attachment J. Tenth Revised and Restated Reporting Requirements

The following table details the Medicaid Managed Care Program reports that the PHP must submit to the Department. The PHP shall submit reports in the format, frequency and method that is defined in the NC PHP Report Guide. The NC PHP Report Guide provides guidance specific to each report. The Department shall maintain the NC PHP Report Guide, along with all applicable report templates, and publish to the PHP via the PHP Contract Data Utility (PCDU) with effective date. If a technical change is made to a template before the next NC PHP Report Guide version is published, a revised template will be posted to the PCDU with its new effective date. Each of the report templates contain specific data elements required, data definitions, and required formats.

Although the State has indicated the reports that are required, the PHP may suggest additional reports.

1. As part of Readiness Activities, the PHP shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
2. The Department reserves the right to require additional reports beyond what is included in this Attachment, which shall be added by Amendment. The PHP shall submit all report formats to the Department for approval. Reports require approval by the Department before being considered final.

Tenth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective July 1, 2025)	
PHP Report Name	**PHP Report Description**
1. ***Administration and Management***	
a. PHP Operating Report	Annual report of each entity identified under the PHP Operating Report, providing evidence of PHP oversight activities and entity performance (i.e. metrics, CAPs, sanctions)
2. ***Members***	
a. PHP Enrollment Extract	Weekly detail and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.
b. Member Services Quality Assurance Report	Quarterly report of survey results which measures member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.
c. Member Marketing and Educational Activities Report	Quarterly summary of Member marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.
d. Reserved.	
e. Reserved.	
f. Annual Member Incentive Programs Report	Annual report of Member outreach, utilization, and metrics for all Member Incentive Programs
g. Member Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the PHP including the total number of appeal and grievance requests filed with the PHP, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.

Tenth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective July 1, 2025)	
PHP Report Name	**PHP Report Description**
h. PHP Enrollment Summary Report	Monthly summary report, and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.
i. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).
j. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report of non-verifiable Member addresses and returned mail.
k. Nursing Facility Admission Disenrollment Report	Ad hoc report on Member disenrollment from a PHP due to a Nursing Facility stay longer than 90 days.
l. Clearinghouse Daily Uploads Extract	Tracking file submitted for each daily or weekly upload to the PCG Clearinghouse of each initial Notice of Adverse Benefit Determination (NABD) and Resolution Notice of Adverse Benefit Determination sent to members.
m. Monthly PHP Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems.
n. Reserved.	
3. ***Benefits and Care Management***	
a. Institute of Mental Disease (IMD) Report	Every other week summary of members who are receiving acute care for SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis code and diagnosis name, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.
b. Pharmacy Benefit Determination/Prior Authorization Report	Monthly report provides summary information on pharmacy prior approval requests.
c. ProDUR Alert Report	Quarterly report highlighting prospective alerts and responses for pharmacy claims.
d. Top GSNs and GC3s Report	Quarterly summary report ranking top GSN and GC3 Medicaid claims.
e. Ad Hoc and Trigger Report	Quarterly report containing activities and ad hoc report, summary of total paid claims, and trigger report with comparison of top 200 GC3s by claim count.
f. EPSDT Report	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.
g. Non-Emergency Medical Transportation (NEMT) Report	Monthly report highlighting the NEMT utilization, monthly requests received, processed, denied and open where the date of service falls within the reporting range.
h. Annual Prevention and Population Health Report	Annual report of all Members outreached, utilization and key program metrics.

Tenth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective July 1, 2025)	
PHP Report Name	**PHP Report Description**
i. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Programs.
j. Enhanced Case Management Pilot Report	Quarterly report of Members served, services used, total costs related to Enhanced Case Management pilots.
k. CMARC and CMHRP Corrective Action Plan Report	Quarterly report on Care Management for At-Risk Children & and Care Management for High- Risk Pregnancy report on corrective action plan and the associated decision reasoning.
l. Care Needs Screening Report	Quarterly report of beneficiary screening results including SDOH and Care Needs Screening.
m. Reserved.	
n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. Reserved.	
p. Nursing Facility Transitions Report	Quarterly report tracking the number and disposition of Members discharged from a nursing facility.
q. Ongoing Transitions of Care Status Report	Monthly report to provide a status update of PHP's ongoing transitions of care (TOC) activities aligned with TOC responsibilities specified in the RFP and the Department's Transitions of Care policy.
r. Reserved.	
s. Reserved.	
t. Reserved.	
u. Service Line Issue Summary Report	Quarterly report to identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.
v. Medical Prior Authorization Extract	Weekly detail data extract of medical prior authorizations.
w. Pharmacy Prior Authorization Extract	Weekly detail data extract of pharmacy prior authorizations.
x. Care Management (CM) Interaction Beneficiary Report	Monthly report of Care Management Interactions from the Designated Care Management Entities.
y. UM and Clinical Coverage Report	Ad Hoc report outlining analysis of compliance with attestation upon request.
z. PCP Operational Monitoring Report	Monthly report on PCP assignment, changes and panel limits.
aa. Clinically Integrated Networks (CIN) Contracting	Monthly report that identifies contracting status between the PHP and Clinically Integrated Networks (CIN) and their affiliated AMH Tier 3 practices.

Tenth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective July 1, 2025)	
PHP Report Name	**PHP Report Description**
Report	
bb. NC Select Drug Report	Quarterly report on requesting drugs on the NC Select Drug List, the status of PA requests, status of paid claims, time to complete PA reviews, and single case provider agreements.
4. ***Providers***	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Reserved.	
c. Reserved.	
d. Reserved.	
e. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for key provider contracting and service functions, provider welcome packets, time to load provider or a provider contract's administrative changes to PHP's claim adjudication and payment systems during the reporting period, including break down of data by provider type and by specified turn-around time periods.
f. Reserved.	
g. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.
h. Network Adequacy Annual Submission Report	Annual and Ad hoc report demonstrating the geographical location of providers in the Provider Network in relationship to where Medicaid Members live.
i. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.
j. Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. To be submitted with the Timely Access Physical Health Provider Appointment Wait Times Report.
k. Reserved.	
l. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. To be submitted with the Timely Access Behavioral Health Provider Appointment Wait Times Report.
m. Reserved	

Tenth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective July 1, 2025)	
PHP Report Name	**PHP Report Description**
n. Provider Grievances, and Appeals Report	Monthly report on log of all provider appeals and grievances and key provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, average time to resolution. 42 C.F.R. § 438.66(c)(3).
o. FQHC RHC Summary Remittance Advice Report	Quarterly report for FQHC/RHC claims data used to enable wrap payments.
p. Local Health Department Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Local Health Dept directed payments.
q. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Public Ambulance Provider directed payments.
r. Reserved.	
s. Out of Network (OON) Service Requests Report	Monthly report on all requests for out-of-network services including status or requests, number of approval or denial, and the decision reasoning
t. Ad-Hoc Network Adequacy Report	Ad hoc report of network adequacy results which measures accessibility data to demonstrate the distance from the Members' residences that a member must travel to reach contracted providers for each of the applicable provider types for adult and pediatric/child populations separately (as applicable).
u. Summary UNC_ECU Physician Claims Report	Quarterly report to capture claims data to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.
v. NEMT Provider Contracting Report	Quarterly report to capture non-emergency provider contracting report at a detailed and summary level from the PHP's.
w. Capitation Reconciliation Report	Monthly report that PHPs will leverage the to inform the State of any capitation related payment discrepancies observed. PHPs will include records of beneficiaries where no payment was received from the State or payment received differed from the amount expected. PHPs will only include beneficiary records with discrepancies on this report to the State. The PHP Capitation Reconciliation Report will be submitted on a monthly cadence. PHPs will indicate expected values and values observed on ASC x12 834 monthly file for beneficiaries.
x. Reserved.	
y. Reserved.	
z. Reserved.	
5. ***Quality and Value***	
a. Reserved.	
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.
c. Reserved	
d. Reserved	

Tenth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective July 1, 2025)	
PHP Report Name	**PHP Report Description**
e. Reserved	
f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
g. Eligible Mothers for Low Birth Weight Extract	Quarterly update on eligible mothers (covered by PHP from 16 weeks gestation or earlier) of all live singleton deliveries within measurement period for low birth weight measure.
6. ***Stakeholder engagement***	
a. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes incl. number served.
b. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PHP to collaborate with county organizations to address issues by county/region.
7. ***Program Administration***	
a. Service Line Report	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.
b. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, electronic communication response rate.
c. Training Evaluation Outcome Report	Annual report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).
d. Reserved.	
8. ***Compliance***	
a. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.
b. Third Party Liability Report	Quarterly claim level detail of third party or cost avoidance activities by the PHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.
c. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by provider including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
d. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by Members including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
e. Overpayment Recoveries Report	Annual report of overpayment recoveries. 42 C.F.R. § 438.604(a)(7).

Tenth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective July 1, 2025)	
PHP Report Name	**PHP Report Description**
f. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
g. Reserved.	
h. Identification of Other Forms of Insurance and Report Start Date of Insurance Coverage Added for Cost Avoidance Report	Quarterly report to record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the Member becoming Medicaid eligible or was enrolled with the PHP. (Section IV.4.d.)
i. Recipient Explanation of Medical Benefit (REOMB) Report	The PHP is responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems. The PHP sends REOMBs to a random sample of Members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the Member(s). The communication includes the provider's name, the date(s) of services, service name, and the payment amount(s). Instructions are included on how to respond to the REOMB. The PHP is required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.
9. ***Financial Requirements***	
a. NC PHP Financial Report	A consolidated reporting packet of all finance related reporting requirements. Specific submission instructions and details are located in the associated companion guide with the report template. Audited Financial Statements submitted as part of this reporting packet must comply with 42 C.F.R. § 438.3(m).
b. Financial Arrangements with Drug Companies Report	Bi-annual report that describes all financial terms and arrangements between the PHP and any pharmaceutical drug manufacturer or distributor.
c. Risk Corridor Service Ratio Report	Interim, Preliminary and Final Risk Corridor Service Ratio reports providing information on the components of the Risk Corridor Service Ratio and Primary Care Expenditure Percentage requirements.
d. NC PHP Claims Monitoring Report	Monthly summary of the volume and dollar amount of claims that were paid, denied, and rejected during the reporting period, and current inventory of pended claims by professional, institutional, and pharmacy. Top 10 denial reasons by volume and dollar amount.
e. TPL Recovery Match Report	A monthly report detailing those claims upon which the PHP has been unable to effectuate recovery within one (1) year of the date of service.
10. ***Healthy Opportunities Pilot***	
a. Reserved.	
b. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the PHP may submit if the Department notifies the PHP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the PHP's anticipated spending through the remainder of the Pilot service delivery

Tenth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective July 1, 2025)	
PHP Report Name	**PHP Report Description**
	year.
c. Healthy Opportunities Pilot Service Delivery Invoice Monitoring Report	Monthly summary of Human Services Organization invoices at the Member Level that have activity during the reporting period.
d. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of PHP Pilot administrative fund spending.
e. Healthy Opportunities Pilot Care Management Assignment Report	Monthly report of Healthy Opportunities Pilot Care Management Assignment. This will be used by the Department to verify Care Management payments for Pilot Enrolled Beneficiaries.
f. Healthy Opportunities Pilot High-Priority Populations Report	Report that the PHP will submit in dual parts: (a) annually, the PHP will submit the Priority Populations Report outlining the PHP's plan for enrolling priority populations, to understand the PHP's enrollment plans and ensure inclusive representation of priority populations. (b) quarterly, the PHP will submit the report outlining aggregate enrollment data for these priority populations, to understand the PHP's progress towards meeting target enrollment as outlined in the Priority Populations Report (a).