Amendment Number 16 (17)
Prepaid Health Plan Services Contract
#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 modify existing requirements and incorporate new requirements to the Contract related to Medicaid Expansion as follows:

I. Modify Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
II. Modify requirements in *Section V. Scope of Services*; and
III. Modify *Attachment J. Sixth Revised and Restated Reporting Requirements*.

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

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

171. **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.
172. **Medicaid Expansion Eligible Members:** NC Medicaid beneficiaries enrolled in Medicaid based on meeting requirements for Medicaid Expansion eligibility category.

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

216. HASP: Healthcare Access and Stabilization Program

II. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

a. *Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, i. Cost Sharing v.* is revised to add the following:

e) Upon approval from CMS, the PHP shall not impose cost-sharing on antiretroviral medications used to treat HIV for the purpose of reducing viral load.

b. ***Section V.D. Providers, 4. Provider Payments*** **is revised to add the following:**

ii. 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 PHP up to the average commercial rate (ACR) for all inpatient and outpatient hospital services, as specified in this Section and approved by CMS. All requirements in this Section are contingent on approval of the HASP preprint for the applicable time period by CMS and subject to change by the Department based on direction from CMS.

ii. All requirements in this Section apply to payments for services incurred during State Fiscal Year (SFY) 2023.

iii. The following hospital classes are eligible to receive HASP payments from the PHP:

a) Class 1: All North Carolina acute care hospitals and critical access hospitals as defined in NCGS § 108A-145.3 included in the PHP's network that are not included in Class 2.

1. An acute care hospital is defined by NCGS § 108A-145.3(1) as a hospital licensed in North Carolina that is not a freestanding psychiatric hospital, a freestanding rehabilitation hospital, a long-term care hospital, or a State-owned and State-operated hospital.
2. A critical access hospital is as defined by 42 C.F.R. § 400.202.

b) Class 2: North Carolina hospitals included in the PHP's network that are owned or controlled by the University of North Carolina Health Care System (UNCHS) and Vidant Medical Center (d/b/a ECU Health Medical Center).

iv. All inpatient and outpatient hospital services are eligible for HASP payments.

v. The PHP shall make interim and final HASP payments based on a uniform percentage increase. The Department will calculate a uniform percentage separately for each hospital class and separately for inpatient and outpatient hospital services based on the methodology described in the directed payment preprint approved by CMS.

vi. HASP payments will first be issued to the PHP on an interim basis for inpatient and outpatient services based on Medicaid Managed Care encounter data for a specified time period and measured as of a date specified by the Department and consistent with preprint approved by CMS.

a) The Department will calculate interim HASP payments for each hospital and PHP by multiplying the applicable uniform percentage increase, as described in *Section V.D.4.ii.v.*, by Medicaid Managed Care base payments from preliminary SFY 2023 encounter data for each hospital and PHP.

b) The Department will disburse to the PHP an amount equal to the total interim payments due to network hospitals (network status is based upon date of service) plus premium tax as calculated pursuant to NCGS § 105-228.5 and NCGS § 58-6-25(b).

c) The PHP shall distribute interim payments to eligible hospitals according to hospital-specific amounts calculated by the Department, as described in *Section*

V.D.4.ii.vi.a), within five (5) Business Days of receiving the payment from the Department. Penalties and interest apply to late payments as described in *Section V.D.4.l.viii.*, except that for the first HASP payment for services incurred during State Fiscal Year (SFY) 2023 to eligible hospitals, penalties as defined in *Section V.D.4.l.viii*., will not apply.

vii. No sooner than six (6) months following the end of the rate year, interim HASP payments will be reconciled by the Department based on actual managed care base payments made for services incurred during the SFY 2023 rate year.

a) The Department will calculate HASP reconciliation amounts as follows:

1. Determine final HASP payment amount for each hospital and PHP by multiplying the applicable uniform percentage increase, as described in *Section V.D.4.ii.v.*, by actual Medicaid Managed Care base payments from SFY 2023 encounter data.
2. Determine the reconciliation amounts for each hospital and PHP by subtracting the HASP interim payment amount, as calculated under *Section V.D.4.ii.vi.a)*, from the final HASP payment amount calculated in *Section V.D.4.ii.vii.a).1*.

b) The Department will calculate and disburse or recoup payments from the PHP based on the reconciliation amounts for network hospitals calculated under *Section V.D.4.ii.vii.a)*. The Department intends to operationalize disbursement or recoupments under this paragraph as an incremental or netting adjustment to a future HASP directed payment transaction and thereby mitigating the need for an additional standalone HASP transaction between the Department and the PHP or between the PHP and the hospital(s). In the event the Department is unable to operationalize the disbursement or recoupment as an incremental or netting transaction for one or more hospitals, the PHP shall do the following:

1. If additional disbursement is needed based on the reconciliation calculation by the Department, the PHP shall distribute HASP payment reconciliation amounts to eligible hospitals according to hospital-specific amounts calculated by the Department, as described in *Section V.D.4.ii.vii.a)*, within five (5) Business Days of receiving the payment from the Department. Penalties and interest apply to late payments as described in *Section V.D.4.l.viii*.
2. If recoupment is needed based on the reconciliation calculation by the Department, the PHP shall issue a notice of recoupment of the HASP payment reconciliation amounts to the eligible hospitals according to hospital-specific amounts calculated by the Department within the time frames defined in *Section V.H.1.f.*

viii. As necessary, the Department will reduce the amount of HASP directed payments to the lowest amount necessary to ensure that aggregate hospital assessments authorized under Article 7B of Chapter 108A of the North Carolina General Statutes do not exceed federal limits established under 42 C.F.R. § 433.68(f).

ix. The requirements specified in *Sections V.D.4.l.i.-ii., Section V.D.4.l.iv.,* and *Sections V.D.4.l.vi.-viii.* shall apply to HASP directed payments, except as provided in *Section V.D.4.ii.vi.c)*.

c. *Section V.I. Financial Requirements, 2. Medical Loss Ratio* is revised to add the following:

i. Minimum Medical Loss Ratio for Medicaid Expansion Eligible Member Population

i. The PHP shall calculate and report a distinct aggregate Department-defined MLR for Medicaid Expansion Eligible Member population on an annual basis aligned to the rating year (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 V.I.2.b.* and *Section V.I.2.c.i.-ii.*of the Contract.
2. The PHP shall provide explanations for any allocation methods required to split expenditures between Medicaid Expansion Eligible Member populations and non-Medicaid Expansion populations in the Department's defined MLR templates.
3. The PHP shall aggregate data for Medicaid Expansion Eligible Members covered under the Contract for purposes of calculating the Department-defined MLR.
4. The PHP 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 year.
5. Payments related to the Healthy Opportunities Pilots shall not be incorporated into the capitation payment nor into the MLR, unless otherwise required by CMS.
6. The PHP shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by the Department.

ii. The CMS-defined MLR shall be reported in aggregate combined for Medicaid Expansion Eligible Member and non-Medicaid Expansion populations as defined in *Section V.I.2.b.i.–iii.* and *Section V.I.2.c.i.-ii.* of the Contract.

iii. If the PHP's Department-defined MLR for Medicaid Expansion Eligible Member population is less than the minimum MLR threshold, the PHP shall do one of the following:

1. 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;
2. Contribute 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.8. Opportunities for Health*; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;
3. Contribute to initiatives that advance public health and Health Equity in alignment with the Department's Quality Strategy, subject to approval by the Department; or
4. Allocate a portion of the total obligation 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.

iv. The minimum MLR threshold in aggregate across all contracted PHPs shall be exactly eighty-eight percent (88%) as required by Section 5.(6)c. of Session Law 2015-245, as amended by Session Law 2018-49. To recognize MLR variability across rate cells, the minimum MLR threshold for the PHP shall be calculated based on the capitation revenue mix of the PHP, by taking the revenue weighted average of each of the Department-calculated factors based on the total capitation payments made for the rating year for each payment category. The minimum MLR threshold shall be calculated separately for the Expansion population in total and the non-Expansion population in total.

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

vi. The PHP shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the PHP 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 the PHP, whichever comes sooner to calculate and validate the accuracy of MLR reporting. 42 C.F.R. § 438.8(k)(3).

vii. In any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the Department, the PHP 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. 42 C.F.R. § 438.8(m).

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

d. *Section V.I. Financial Requirements, 4. Risk Corridor, a.* is revised and restated to make a technical correction to the reference for "Reported Services Ratio" as stated below. There are no other revisions within this subsection a.

a. A risk corridor arrangement between the PHP and the Department will apply to share in gains and losses of the PHP as defined in this section. The Risk Corridor payments to and recoupments from the PHP will be based on a comparison of the PHP's reported Risk Corridor Services Ratio ("Reported Services Ratio") for each Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in the Standard Plan Rate Book ("Target Services Ratio").

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

b. Risk Corridor for Medicaid Expansion Eligible Member Populations

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

ii. Determination of payments and recoupments for Medicaid Expansion Eligible Member populations will be calculated separately from the non- Medicaid Expansion population.
    a) The Risk Corridor Measurement Period for the Medicaid Expansion Eligible Member population is defined as:
        i. For Period 1: the start of Medicaid Expansion to June 30, 2024.
    b) The numerator and denominator calculations for the Target Services Ratio and Reported Services Ratios, including exclusions, will be consistent with those defined in *Section V.I.4.a.v.–vii.* of the Contract.
    c) The risk corridor payments and recoupments will be based on a comparison of PHP's Reported Services Ratio for each measurement period to a Target Services Ratio derived from capitation rate-setting by the Department. The Target Services Ratio will be documented in the Standard Plan Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.
    d) The PHP Target Services Ratio for Expansion populations shall be calculated using the Target Services Ratio for each applicable 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).
    e) The PHP shall calculate the numerator and denominator terms of the Reported Services Ratio based on actual experience for the applicable Risk Corridor Measurement Period and report them to the Department in a format prescribed by the Department.
    f) The PHP shall provide an attestation of the accuracy of the Information provided in its submitted risk corridor calculations, including minimum PCP Expenditure requirement calculation, as specified in 42 C.F.R. § 438.606.
    g) Terms of the Risk Corridor
        i. If the Reported Services Ratio is less than the Target Services Ratio minus three percent (3%), the PHP shall pay the Department fifty percent (50%) 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 PHP fifty percent (50%) of the Reported Services Ratio denominator multiplied by the difference of the Reported Services Ratio and the Target Services Ratio plus three percent (3%).

iii. Risk Corridor Settlement and Payments
    a) The Department will complete a settlement determination for each Risk Corridor Measurement Period. This determination shall be made for the Medicaid Expansion Eligible Member population independent of the non-Medicaid Expansion population determination.
    b) The PHP shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
    c) The PHP shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.

d) The PHP shall provide explanations for any allocation methods required to split expenditures between Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.
e) The PHP shall provide additional information and documentation at the request of the Department to support the Risk Corridor Settlement determination.
f) The Department may choose to review or audit any information submitted by the PHP.
g) The Department will complete a Risk Corridor Settlement determination for each Risk Corridor Measurement Period. In preparing the settlement, the Department will make final decisions about covered costs included in the settlement.
h) The Department will provide the PHP 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.A.e.vii. Dispute Resolution* within thirty (30) Calendar Days of the notice by the Department to the PHP.
i) If the final Risk Corridor Settlement requires the PHP to remit funds to the Department, the PHP 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.
j) At the sole discretion of the Department, the Department may allow the PHP to contribute all or a part of the amount otherwise to be remitted to:
    i. 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.
    ii. Contribute to initiatives that advance Health Equity in alignment with the Department's Quality Strategy that have been reviewed and approved by the Department.
    iii. To be considered for the in lieu of remittance option, the PHP must submit a proposal to the Department for review and approval concurrent with or prior to submission of the PHP's interim Risk Corridor Services Ratio report.
    iv. If the PHP has not made a required remittance payment within the final date required by this Section, the Department may choose to recover any obligation due from the PHP by offsetting a subsequent monthly capitation payment.
    v. If the final Risk Corridor Settlement requires the Department to make additional payment to the PHP, the Department shall initiate payment within ninety (90) Calendar Days after the Department's notification of the final Risk Corridor settlement. If the PHP initiates a dispute as described in *Section VI.A.e.vii. Dispute Resolution,* the deadline for the Department to make the additional required payments shall be stayed pending the outcome of the dispute.

vi. The Medicaid Expansion Eligible Member population risk corridor shall be settled in advance of the final minimum Medicaid Expansion MLR reporting and determination.

III. Modifications to Section VII. Attachments

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

IV. Effective Date

This Amendment is effective October 1, 2023, 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

_____ Date: _____

Jay Ludlam, Deputy Secretary
NC Medicaid

Plan Name

_____ Date: _____

Plan Signature Authority

Attachment J: Seventh 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.

Seventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
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.
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 ninety (90) Calendar 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	Alternate-week report providing the prior two calendar weeks' summary of members who are receiving SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provide NPI, facility admission date and facility discharge date.
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.
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. Quarterly Admission and Readmission Report	Quarterly summary report of admission and readmission trends.
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 Assignment Monitoring Report	Biweekly report on PCP assignment, changes, and panel limits.
4. ***Providers***	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Reserved.	[redacted]
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.	[redacted]
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.	[redacted]

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	
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. UNC Vidant Hospital Directed Payment	Quarterly report to collect claims data to support outpatient directed payments to UNC / Vidant Hospitals.

Report Data – Outpatient	
z. UNC Vidant Hospital Directed Payment Report Data – Inpatient	Quarterly report to collect claims data to support inpatient directed payments to UNC / Vidant Hospitals.
5. ***Quality and Value***	
a. QAPI Progress Report	Quarterly QAPI update on activities outlined in the QAPI.
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.
c. Reserved	[redacted]
d. Reserved	
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.	[redacted]
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).
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.*)
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.
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 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).