Amendment Number 6/7
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 or PHP), each, a Party and collectively, the Parties.

Background:
The purpose of this Amendment is to make technical corrections, including a revision to the Terms and Conditions to comply with CMS issued guidance regarding program features no longer required by law, and state the approved In Lieu of Services in the following Sections of the Revised and Restated Request for Proposal #30-190029-DHB:

1. Section III.D. Terms and Conditions;
2. Section V. Scope of Services;
3. Section VII. Attachments A – N; and
4. Section X. Summary of Contractual Payment and Risk Sharing Terms.

The Parties agree as follows:

1. Section III.D. Terms and Conditions is revised to incorporate the modifications as stated below.

a. Effective January 1, 2021, *22. GOVERNMENTAL RESTRICTIONS* is revised and restated as follows:

22. GOVERNMENTAL RESTRICTIONS:

a. In the event any governmental restrictions are imposed which necessitate alteration of the material, quality, workmanship, or performance of the items or services offered prior to their delivery, it shall be the responsibility of the Contractor to notify, in writing, the issuing Department immediately, indicating the specific regulation which required such alterations. The Department reserves the right to accept any such alterations, including any price adjustments occasioned thereby, or to cancel the Contract.

b. Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part of the Contract after the effective date of the loss of program authority. The Department must adjust the capitation rates specified in *Section X. Summary of Contractual Payment and Risk Sharing Terms* of the Contract to remove costs that are specific to any program or activity under the Contract that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor shall not be paid for that work. If the Department paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work shall be returned to the Department. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

b. 32. <u>PAYMENTS AND REIMBURSEMENT</u> is revised and restated to add the following:

l. COVID-19 Vaccination Member Incentive Program:

i. The Department will make payments to the Contractor for fifty percent (50%) of expenditures on the COVID-19 Vaccination Member Incentive Program up to $1,000,000 in Contract Year 1.
   a. The PHP shall limit Member Incentives to no more than two hundred dollars ($200) per Member during Contract Year 1.
   b. The Department will provide reimbursement for the administration and payment of incentives in the Contractor's COVID-19 Vaccination Member Incentive Program. The Department will limit reimbursement to the Contractor for the administration of the COVID-19 Vaccination Member Incentive Program to no more than twenty percent (20%) of the total payments to the Contractor.

ii. The Department will make payment to the Contractor sixty (60) Calendar Days after receipt of a complete COVID-19 Member Incentive Program Expenditure Report for Contract Year 1.

2. Modifications to Section V. Scope of Services

a. Section V.B. Members, Member Engagement is revised and restated to add the following:

s. COVID-19 Vaccination Member Incentive Program

i. The PHP may establish a COVID-19 Vaccine Member Incentive Program that provides an incentive for Members who receive a COVID-19 vaccine. The PHP shall submit to the Department a COVID-19 Vaccine Member Incentive Program Policy for review and approval no later than September 30, 2021. The Policy shall include:
   a) Type of incentive(s) offered and method(s) for administering the program;
   b) Method and timing of distributing incentive (i.e., by mail, electronic, in person)
   c) Approach to:
      1. Focus incentives to communities within the PHP's Region(s) with low COVID-19 vaccination rates;
      2. Focus incentives to historically marginalized group and communities;
      3. Help assure equitable distribution of incentives in order to assure equitable outcome for Members; and
      4. Ensure incentives are not discriminatory in violation of any applicable federal or State law;
   d) Appropriate safeguards to ensure that incentives are received only by a Member, or by the legal guardian of the Member, who receive a COVID-19 vaccination; and
   e) Appropriate safeguards to prevent abuse of the program by Members and to ensure compliance with all existing federal requirements regarding payments to Members.

ii. The PHP shall maintain and share with the Department documentation of expenditures, incentives provided, including member information and vaccine provider data through the COVID-19 Vaccination Member Incentive Program.

iii. The COVID-19 Vaccination Member Incentive Program is separate and distinct from the Member Incentive Program and shall not be subject to the seventy-five dollar ($75.00) annual limit on healthy behavior incentives that may be provided to a Member under the Member Incentive Program.

b. First Revised and Restated Section V.C. Table 2: Services Carved Out of Medicaid Managed Care is revised and restated as follows:

Second Revised and Restated Section V.C. Table 2: Services Carved Out of Medicaid Managed Care[10]
Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services documented in an individualized family service plan under the Individuals with Disabilities Education Act, 20 U.S.C. § 1436, that are provided and billed by Children's Developmental Services Agency (CDSA) or by a provider contracted with a CDSA to provide those services.
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.
Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

c. Section V. Scope of Services D. Providers 4. Provider Payments e. Hospital Payments (Excluding Behavioral Health Claims) iii. is revised and restated as follows:

iii. The applicable rate floor and methodology for outpatient hospital services (excluding hospital outpatient laboratory services), including Emergency Department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.

a. The applicable rate floor and methodology for in-network hospital outpatient laboratory services shall be 146.38% of the Medicaid Fee-for-Service Laboratory fee schedule rate in effect on February 28, 2020, unless the PHP and hospital have mutually agreed to an alternative reimbursement amount or methodology.

d. Section V. Scope of Services D. Providers 4. Provider Payments p. Advance Medical Home Payments ii. is revised and restated as follows:

i. The PHP shall pay Medical Home Fees to AMH Tiers 1 – 3 practices for any month in which the Member is assigned to that AMH practice. Medical Home Fees for AMH Tiers 1 – 3 practices may be prorated for partial months and shall be no less than the Medical Home payment in NC Medicaid Fee-for-Service applicable to Carolina ACCESS II providers or if applicable, the Cherokee Indian Health Authority for the first two (2) Contract Years. The PHPs shall make retrospective payments to AMH Tiers 1-3 back to the beginning of Contract Year 1 no later than forty-five (45) days after execution of the amendment.

[10] G.S. 108D-35.

3. **Modifications to Section VII. Attachments A-N of the Contract.**

   Specific attachments and subsections are modified as stated herein.

   a. Section VIII. Attachment J: First Revised and Restated Reporting Requirements, is revised and restated in its entirety as *Section VIII. Attachment J: Second Revised and Restated Reporting Requirements*.

   b. Section VIII. is modified to add *Attachment M.10. Approved PHP Name In Lieu of Services*.

4. **Section X. Summary of Contractual Payment and Risk Sharing Terms is revised and restated in its entirety as *Section X. First Revised and Restated Summary of Contractual Payment and Risk Sharing Terms*** and attached to this Amendment.

5. **Effective Date:** This Amendment is effective upon the later of the execution dates by the Parties, subject to approval by CMS.

6. **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.

PHP Name

_____ Date: _____

PHP Contact

Department of Health and Human Services

_____ Date: _____

Dave Richard
Deputy Secretary
NC Medicaid

Attachments to the Amendment

Attachment J: Second Revised and Restated Reporting Requirements

Attachment M.10. Approved PHP Name In Lieu of Services

Section X. First Revised and Restated Summary of Contractual Payment and Risk Sharing Terms

Attachment J. Second 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.

Second 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. Planned Marketing Procedures, Activities, and Methods	Annual report of planned marketing activities including number/types of events, locations, description of materials distributed, and number of Members reached.
e. Quarterly Member Incentive Programs Report	Quarterly report of Member outreach, utilization, and metrics for all Member Incentive Programs
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 90 days.
l. Clearinghouse Daily Uploads Extract	Tracking file submitted for each daily or monthly 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. COVID-19 Vaccine Incentive Program Report	Monthly report to include cumulative Member level details on COVID-19 Vaccination Member Incentive Program, including Member information, vaccine provider data, incentives provided and expenditures.
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. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management payments.

n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. AMH Integration Contracting Report	Monthly AMH Tier 3 practices contracting and integration status report
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. High Needs Members Follow Up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members.
s. Crossover-Related NEMT Appointments Scheduled Report	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.
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.
4. ***Providers***	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Network Adequacy Exceptions Report	Quarterly report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies.
c. Network Adequacy Exceptions Narrative Report	Quarterly narrative report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies. Submit with PRV001-J Network Adequacy Exceptions Report

d. Essential Provider Alternate Arrangements Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy.
e. Provider Contracting Determinations and Activities Report	Quarterly and ad hoc report providing the turn-around-time and statistics for key provider contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made by the during the reporting period, including break down of data by provider type and by specified turn-around time periods.
f. Provider Contracting Determinations and Activities Narrative Report	Quarterly and ad hoc narrative report providing the turn-around-time and statistics for key provider contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made by the during the reporting period, including break down of data by provider type and by specified turn-around time periods. Submit with PRV005-J: Provider Contracting Determinations and Activities Narrative Report.
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. Essential Provider Alternate Arrangements Narrative Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how Members needs are being

	met, the PHPs work to alleviate the inadequacy. To be submitted with the Essential Alternate Arrangements Report.
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	Reserved
n. Provider Grievances, Appeals, and Litigated 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. Provider Quality Assurance Report	Quarterly report of survey results which measures providers' 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.
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. Suspended and Terminated Providers Report	Monthly report showing suspended claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements. PHP shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) days of suspension, the Department will terminate the provider from Medicaid. Referenced in V.D.2.j.i.a / V.D.2.j.i.b.
y. UNC Vidant Hospital Directed Payment Report Data – Outpatient	Quarterly report to collect claims data to support outpatient directed payments to UNC / Vidant Hospitals.
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. VBP Assessment	Annual retrospective report documenting VBP contracts in place and payments made under VBP arrangements.
d. VBP Strategy Report	Annual report projecting VBP contracts and payments expected to be made under VBP arrangements in the coming Contract Year. These templates should be included in PHPs' VBP Strategies submitted to the Department annually.
e. VBP Strategy Narrative Report	Annual report projecting VBP contracts and payments expected to be made under VBP arrangements in the coming year. These templates should be included in PHPs' VBP Strategies submitted to the Department annually. To be submitted with VBP Strategy Templates.

f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
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	Quarterly 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. Secondary Call Center Service Line Report	Monthly secondary call center service line utilization and statistics.
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. Other Member Complaints Report	Monthly report detailing a cumulative listing of Member complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
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. 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.
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	Weekly 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.

SECTION X. First Revised and Restated Summary of Contractual Payment and Risk Sharing Terms

A. This Section summarizes July 1, 2021-September 30, 2021 capitation payment and risk sharing terms and figures included the Standard Plan Rate Book for State Fiscal Year 2022dated October 8, 2021. Beginning in August 2021, the ABD, TANF and Other Related Children ages 1–20, and TANF and Other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Base Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,638.69	$1,568.54	$1,805.36	$1,651.78	$1,508.27	$1,482.06
TANF, Newborns (<1)	$979.21	$814.62	$901.66	$842.13	$805.08	$843.07
TANF, Children (1–20)	$181.70	$160.32	$169.46	$155.08	$159.47	$155.19
TANF, Adults (21+)	$406.17	$412.71	$417.29	$403.51	$423.37	$403.99
Maternity Event	$11,174.86	$10,737.45	$12,097.22	$10,996.25	$10,547.38	$11,544.12

PMPM Add-on for Legislative Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$14.25	$13.94	$16.08	$14.93	$14.02	$14.55
TANF, Newborns (<1)	$6.91	$7.26	$8.02	$7.52	$8.33	$7.88
TANF, Children (1–20)	$2.79	$2.48	$2.72	$2.42	$2.53	$2.41
TANF, Adults (21+)	$5.03	$5.70	$5.76	$5.85	$6.28	$5.61
Maternity Event	$104.73	$113.68	$120.26	$107.08	$118.37	$119.99

PMPM Add-on for DHHS Authorized Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$22.90	$23.88	$32.55	$27.51	$23.41	$26.43
TANF, Newborns (<1)	$6.62	$6.49	$5.01	$6.76	$5.27	$5.90
TANF, Children (1–20)	$4.28	$3.76	$3.29	$3.87	$3.65	$3.61
TANF, Adults (21+)	$3.63	$2.31	$2.69	$2.96	$3.24	$3.40
Maternity Event	$41.10	$6.01	$9.79	$31.70	$15.16	$46.57

Target Service Ratio Underlying Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	92.5%	91.8%	92.3%	91.8%	92.1%	92.1%
TANF, Newborns (<1)	91.8%	91.1%	91.6%	91.0%	91.3%	91.4%
TANF, Children (1–20)	89.0%	88.5%	88.6%	87.8%	88.1%	88.6%
TANF, Adults (21+)	90.7%	90.2%	90.5%	90.0%	90.4%	90.4%
Maternity Event	95.1%	94.6%	94.9%	94.6%	94.8%	94.9%

Target Service Ratios Underlying COVID-19 Add-Ons

COA/Region	Legislative Add-Ons	DHHS Rate Action Add-Ons
All COA, All Regions	98.75%	98.75%

Minimum PCP Expenditures as a Percentage of Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.4%	4.9%	4.7%	4.6%	5.3%	4.8%
TANF, Newborns (<1)	11.5%	15.2%	14.1%	13.8%	15.4%	13.4%
TANF, Children (1–20)	17.6%	18.9%	18.5%	18.1%	18.3%	17.5%
TANF, Adults (21+)	8.6%	8.8%	9.1%	9.1%	10.3%	8.9%
Maternity Event	15.4%	15.9%	15.5%	15.5%	16.8%	16.5%

Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard Plan
89.1%	88.7%	85.8%	88.0%	91.9%	88.0%

B. This Section summarizes October 1, 2021-June 30, 2022 capitation payment and risk sharing terms and figures included the Standard Plan Rate Book for State Fiscal Year 2022 dated September 2, 2021. Beginning in August 2021, the ABD, TANF and Other Related Children ages 1–20, and TANF and Other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Base Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,638.69	$1,568.54	$1,805.36	$1,651.78	$1,508.27	$1,482.06
TANF, Newborns (<1)	$979.21	$814.62	$901.66	$842.13	$805.08	$843.07
TANF, Children (1–20)	$181.70	$160.32	$169.46	$155.08	$159.47	$155.19
TANF, Adults (21+)	$406.17	$412.71	$417.29	$403.51	$423.37	$403.99
Maternity Event	$11,174.86	$10,737.45	$12,097.22	$10,996.25	$10,547.38	$11,544.12

PMPM Add-on for Legislative Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$14.25	$13.94	$16.08	$14.93	$14.02	$14.55
TANF, Newborns (<1)	$6.91	$7.26	$8.02	$7.52	$8.33	$7.88
TANF, Children (1–20)	$2.79	$2.48	$2.72	$2.42	$2.53	$2.41
TANF, Adults (21+)	$5.03	$5.70	$5.76	$5.85	$6.28	$5.61
Maternity Event	$104.73	$113.68	$120.26	$107.08	$118.37	$119.99

PMPM Add-on for DHHS Authorized Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$18.30	$18.87	$24.17	$20.24	$16.87	$19.72
TANF, Newborns (<1)	$4.69	$4.74	$4.67	$4.76	$4.45	$4.62
TANF, Children (1–20)	$3.25	$3.10	$3.08	$3.27	$3.25	$3.11
TANF, Adults (21+)	$2.15	$1.94	$2.11	$2.01	$2.27	$2.29
Maternity Event	$12.00	$3.21	$7.15	$14.88	$6.87	$16.93

Target Service Ratio Underlying Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	92.5%	91.8%	92.3%	91.8%	92.1%	92.1%
TANF, Newborns (<1)	91.8%	91.1%	91.6%	91.0%	91.3%	91.4%
TANF, Children (1–20)	89.0%	88.5%	88.6%	87.8%	88.1%	88.6%
TANF, Adults (21+)	90.7%	90.2%	90.5%	90.0%	90.4%	90.4%
Maternity Event	95.1%	94.6%	94.9%	94.6%	94.8%	94.9%

Target Service Ratios Underlying COVID-19 Add-Ons

COA/Region	Legislative Add-Ons	DHHS Rate Action Add-Ons
All COA, All Regions	98.75%	98.75%

Minimum PCP Expenditures as a Percentage of Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.4%	4.9%	4.7%	4.6%	5.3%	4.8%
TANF, Newborns (<1)	11.5%	15.2%	14.1%	13.8%	15.4%	13.4%
TANF, Children (1–20)	17.6%	18.9%	18.5%	18.1%	18.3%	17.5%
TANF, Adults (21+)	8.6%	8.8%	9.1%	9.1%	10.3%	8.9%
Maternity Event	15.4%	15.9%	15.5%	15.5%	16.8%	16.5%

Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard Plan
89.1%	88.7%	85.8%	88.0%	91.9%	88.0%