AMENDMENT #3

CONTRACT #00000000000000000000069655

This is an Amendment to the Contract (the "Contract") entered into by and between **the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning ("FSSA")** (the "State") and **Coordinated Care Corporation d/b/a Managed Health Services** (the "Contractor") approved by the last State signatory on March 1, 2023.

In consideration of the mutual undertakings and covenants hereinafter set forth, the parties agree as follows:

The Contract for providing risk-based managed care services to Medicaid beneficiaries enrolled in the State of Indiana's Healthy Indiana Plan program is hereby amended to update Exhibits 1.A, 2.A, 3.A, 4, 5.A and 6.A.

Exhibit 1.A, which outlines the Scope of Work, is hereby superseded and replaced by **Exhibit 1.B**, which is attached hereto and incorporated herein.

Exhibit 2.A, which outlines the Contract Compliance and Pay for Outcomes, is hereby superseded and replaced by **Exhibit 2.B**, which is attached hereto and incorporated herein.

Exhibit 3.A, which outlines the Program Description and Covered Benefits, is hereby superseded and replaced by **Exhibit 3.B**, which is attached hereto and incorporated herein.

Exhibit 4, which outlines the Responsibilities of the State, is hereby superseded and replaced by **Exhibit 4.A**, which is attached hereto and incorporated herein.

Exhibit 5.A, which outlines the Contract Definitions, is hereby superseded and replaced by **Exhibit 5.B**, which is attached hereto and incorporated herein.

Exhibit 6.A, which outlines the State's Capitation Rates, is hereby superseded and replaced by **Exhibit 6.B**, which is attached hereto and incorporated herein.

Funding in the amount of $244,821,346.08 is being added to the total contract amount. Total remuneration under the Contract is not to exceed **$4,173,991,364.62**.

The Contractor's Division of Supplier Diversity ("DSD") ongoing obligations have been updated as detailed in the IDOA DSD Letter of Determination, dated March 8, 2024, and are as follows:

A. **Clause 26. Indiana Veteran Owned Small Business Enterprise Compliance** remains unchanged with a 0% change in overall commitment obligations. Therefore, Clause 26 remains as follows:

   Award of this Contract was based, in part, on the Indiana Veteran Owned Small Business Enterprise ("IVOSB") participation plan, as detailed in the IVOSB Subcontractor Commitment Form, commonly referred to as "Attachment A-1" in the procurement documentation and incorporated by reference herein. Therefore, any changes to this information during the Contract term must be approved by IDOA's Division of Supplier Diversity and may require an amendment. It is the State's expectation that the Contractor will meet the subcontractor commitments during the Contract term. The following certified IVOSB subcontractor(s) will be participating in this Contract:

IVB	PHONE	COMPANY NAME	SCOPE OF PRODUCTS and/or SERVICES	UTILIZATION DATE	PERCENT
IVOSB	(317) 605-3896	Patriot Ventures, LLC. d.b.a Patriot Insurance and Risk Management Services	Provide strategic benefit planning and management of reinsurance transactions	1/1/23-12/31/26	0.03%
IVOSB	(410) 533-6247	Vespa Group	Provide recruiting, staffing, and resource management needs and IT support	1/1/23-12/31/26	3.78%

A copy of each subcontractor agreement must be submitted to the Division of Supplier Diversity within thirty (30) days of the effective date of this Contract. The subcontractor agreements may be uploaded into Pay Audit (Indiana's subcontractor payment auditing system), emailed to IndianaVeteransPreference@idoa.IN.gov, or mailed to IDOA, 402 W. Washington Street, Room W-462, Indianapolis, IN 46204. Failure to provide a copy of any subcontractor agreement may be deemed a violation of the rules governing IVOSB procurement and may result in sanctions allowable under 25 IAC 9-5-2. Requests for changes must be submitted to IndianaVeteransPreference@idoa.IN.gov for review and approval before changing the participation plan submitted in connection with this Contract.

The Contractor shall report payments made to certified IVOSB subcontractors under this Contract on a monthly basis using Pay Audit. The Contractor shall notify subcontractors that they must confirm payments received from the Contractor in Pay Audit. The Pay Audit system can be accessed on the IDOA webpage at: www.in.gov/idoa/mwbe/payaudit.htm. The Contractor may also be required to report IVOSB certified subcontractor payments directly to the Division of Supplier Diversity, as reasonably requested and in the format required by the Division of Supplier Diversity.

The Contractor's failure to comply with the provisions in this clause may be considered a material breach of the Contract.

B. **Clause 32. Minority and Women's Business Enterprises Compliance** is changed to reflect a decrease of the IDOA-certified MBE LCP Transportation, LLC from 16.28% to 13.88%. The change results in a 2.4% decrease in overall commitment obligations for Minority Business Enterprises Compliance and a 0% change in overall commitment obligations for Women's Business Enterprises Compliance. Therefore, Clause 32 is modified as follows:

Award of this Contract was based, in part, on the Minority and/or Women's Business Enterprise ("MBE" and/or "WBE") participation plan as detailed in the Minority and Women's Business Enterprises Subcontractor Commitment Form, commonly referred to as "Attachment A" in the procurement documentation and incorporated by reference herein. Therefore, any changes to this information during the Contract term must be approved by the Division of Supplier Diversity and may require an amendment. It is the State's expectation that the Contractor will meet the subcontractor commitments during the Contract term.

The following Division of Supplier Diversity certified MBE and/or WBE subcontractors will be participating in this Contract:

MBE/WBE	PHONE	COMPANY NAME	SCOPE OF PRODUCTS and/or SERVICES	UTILIZATION DATE	PERCENT
MBE	(317) 493-2000	Bucher & Christian Consulting, Inc. d.b.a BCforward	Provide vendor management services	1/1/23-12/31/26	0.51%
WBE	(844) 366-2587	Clover Senior Care	Provide home care visits for new members to assist completing health needs screenings, social determinants of health screenings, and potential gaps in care	1/1/23-12/31/26	0.86%
WBE	(317) 571-0051	Coles Marketing Communications, Inc.	Provide marketing consulting services, graphic design, medical relations services, staffing and advertising buy services	1/1/23-12/31/26	1.89%
WBE	(317) 634-0281	Colored Threads	Provide consulting on and supply of promotional items for community outreach and small incentive items	1/1/23-12/31/26	0.01%
MBE	(404) 610-3200	CulturaLink, Inc.	Provide interpreters to deliver culturally competent care	1/1/23-12/31/26	0.14%
WBE	(317) 283-8300	Engaging Solutions, LLC	Provide staffing for outbound member education/outreach calls and inbound member calls	1/1/23-12/31/26	3.04%
MBE	(317) 872-4490	Fineline Graphics d.b,a Fineline Printing Group	Provide printing and mailing services and promotional merchandising services	1/1/23-12/31/26	0.30%
MBE	(317) 926-4011	Indiana Minority Health Coalition, Inc. d.b,a IMHC	Provide outreach, training, maternal/child support services, and health equity fund development	1/1/23-9/26/23	1.39%
MBE	(317) 926-4011	Indiana Minority Health Coalition, Inc. d.b,a IMHC	Provide outreach, training, maternal/child support services, and health equity fund development	9/27/23-12/31/26	1.182%
WBE	(317) 896-9619	Keith Marketing Group	Provide marketing services	1/1/23-12/31/26	0.02%
MBE	(317) 291-9318	LCP Transportation, LLC	Provide unlimited transportation services for members	1/1/23-3/7/24	16.28%
MBE	(317) 291-9318	LCP Transportation, LLC	Provide unlimited transportation services for members	3/8/24-12/31/26	13.88%
WBE	(317) 218-0650	RepuCare, Inc.	Provide recruiting, staffing, resource management needs	1/1/23-12/31/26	1.69%
WBE	(812) 369-0385	RoBailey Consulting, LLC	Provide consulting services with IHCP government program policies and regulations know ledge and experience.	1/1/23-12/31/26	3.11%
MBE	(317) 922-0922	Sahasra Technologies Corp dba STLogics	Provide Chat Bot functionality to enhance customer service	1/1/23-12/31/26	0.30%
MBE	(317) 258-6429	Black Onyx Management, Inc.	Provide outreach, training, maternal/child support services, and	9/27/2023-12/31/2026	0.203%

			health equity fund development		

A copy of each subcontractor agreement must be submitted to the Division of Supplier Diversity within thirty (30) days of the effective date of this Amendment. The subcontractor agreements may be uploaded into Pay Audit (Indiana's subcontractor payment auditing system), emailed to MWBECompliance@idoa.IN.gov, or mailed to the Division of Supplier Diversity, 402 W. Washington Street Room W-462, Indianapolis IN 46204. Failure to provide a copy of any subcontractor agreement may be deemed a violation of the rules governing MBE/WBE procurement and may result in sanctions allowable under 25 IAC 5-7-8. Requests for changes must be submitted to MWBECompliance@idoa.IN.gov for review and approval before changing the participation plan submitted in connection with this Amendment.

The Contractor shall report payments made to Division of Supplier Diversity certified subcontractors under this Contract on a monthly basis using Pay Audit. The Contractor shall notify subcontractors that they must confirm payments received from Contractor in Pay Audit. The Pay Audit system can be accessed on the IDOA webpage at: www.in.gov/idoa/mwbe/payaudit.htm. Contractor may also be required to report Division of Supplier Diversity certified subcontractor payments directly to the Division of Supplier Diversity, as reasonably requested and in the format required by the Division of Supplier Diversity.

Contractor's failure to comply with the provisions in this clause may be considered a material breach of the Contract.

Additionally, Clause 34 Notice to Parties is hereby deleted and the following substituted therefore:

34. Notice to Parties

Whenever any notice, statement or other communication is required under this Contract, it will be sent by E-mail or first-class U.S. mail service to the following addresses, unless otherwise specifically advised.

A. Notices to the State shall be sent to:

Cora Steinmetz, Medicaid Director
Indiana Family and Social Services Administration,
Office of Medicaid Policy and Planning
402 W. Washington Street, Room W371
Indianapolis, IN 46204
Email: cora.steinmetz@fssa.in.gov

B. Notices to the Contractor shall be sent to:

Kevin O'Toole, President and Executive Officer
Coordinated Care Corporation, d.b.a. Managed Health Services
429 N. Pennsylvania Avenue
Indianapolis, Indiana 46204
Email: kevin.m.otoole@mhsindiana.com

As required by IC § 4-13-2-14.8, payments to the Contractor shall be made via electronic funds transfer in accordance with instructions filed by the Contractor with the Indiana Auditor of State.

All other matters previously agreed to and set forth in the original Contract and Amendment #1 and not affected by this Amendment shall remain in full force and effect.

THE REMAINDER OF THIS PAGE HAS BEEN INTENTIONALLY LEFT BLANK

Non-Collusion and Acceptance

The undersigned attests, subject to the penalties for perjury, that the undersigned is the Contractor, or that the undersigned is the properly authorized representative, agent, member or officer of the Contractor. Further, to the undersigned's knowledge, neither the undersigned nor any other member, employee, representative, agent or officer of the Contractor, directly or indirectly, has entered into or been offered any sum of money or other consideration for the execution of this Contract other than that which appears upon the face hereof. **Furthermore, if the undersigned has knowledge that a state officer, employee, or special state appointee, as those terms are defined in IC § 4-2-6-1, has a financial interest in the Contract, the Contractor attests to compliance with the disclosure requirements in IC § 4-2-6-10.5.**

Agreement to Use Electronic Signatures

I agree, and it is my intent, to sign this Contract by accessing State of Indiana Supplier Portal using the secure password assigned to me and by electronically submitting this Contract to the State of Indiana. I understand that my signing and submitting this Contract in this fashion is the legal equivalent of having placed my handwritten signature on the submitted Contract and this affirmation. I understand and agree that by electronically signing and submitting this Contract in this fashion I am affirming to the truth of the information contained therein. I understand that this Contract will not become binding on the State until it has been approved by the Department of Administration, the State Budget Agency, and the Office of the Attorney General, which approvals will be posted on the Active Contracts Database: https://secure.in.gov/apps/idoa/contractsearch/

In Witness Whereof, the Contractor and the State have, through their duly authorized representatives, entered into this Contract. The parties, having read and understood the foregoing terms of this Contract, do by their respective signatures dated below agree to the terms thereof.

Coordinated Care Corporation d/b/a Managed Health Services

DocuSigned by:
By: Kevin O'Toole
EFDD7B78D1CC475...

Title: CEO

Date: 9/27/2024 | 07:14 PDT

Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning

Signed by:
By: Cora Ann Steinmetz – 00503
A1FAD1BE95044DA...

Title: Medicaid Director

Date: 9/27/2024 | 10:15 EDT

Electronically Approved by: Indiana Office of Technology By: (for) Tracy Barnes, Chief Information Officer	Electronically Approved by: Department of Administration By: (for) Rebecca Holwerda, Commissioner
Electronically Approved by: State Budget Agency By: (for) Joseph M. Habig, Acting State Budget Director	Electronically Approved as to Form and Legality: Office of the Attorney General By: (for) Theodore E. Rokita, Attorney General

EXHIBIT 1B

SCOPE OF WORK – HEALTHY INDIANA PLAN

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EXHIBIT 1B

SCOPE OF WORK – HEALTHY INDIANA PLAN

This Scope of Work is part of a Contract to provide risk-based managed care services to Medicaid beneficiaries enrolled in the State of Indiana's Healthy Indiana Plan (HIP) program. The State is looking to contract on a statewide basis with managed care entities (MCEs) with a demonstrated capacity to actively manage care for a low-income population.

Because HIP is financed in part by federal Medicaid funds, Contractors shall meet all applicable requirements of Medicaid managed care organizations under Section 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438**, which defines requirements for Medicaid managed care programs.** Contractors shall also ensure that its network providers, including out-of-state providers, enroll in the Indiana Health Coverage Programs (IHCP) before they begin providing health care services to members.

Unless otherwise indicated, the requirements set forth in this Scope of Work apply to the Contractor's responsibilities under the HIP program.

1.0 Background

The Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) manages the HIP program. For purposes of this Scope of Work, the term "FSSA" shall refer to the agency and its divisions, including, but not limited to OMPP. HIP is one of the Medicaid programs that helps over 390,000 Hoosiers.[1] HIP aims to provide comprehensive health care coverage for Hoosier families.

A brief description of the HIP program is outlined below. The HIP program seeks not only to provide health coverage to an uninsured population, but to improve health, promote prevention and encourage healthy lifestyles.

The Contractor shall perform the administrative functions of a typical insurer, address the unique challenges of low-income populations, and manage and integrate care along the continuum of health care services. Goals for the HIP program include:

- Improve health outcomes;
- Promote primary and preventive care;
- Foster personal responsibility and healthy lifestyles;
- Assure the appropriate use of health care services;
- Develop informed health care consumers by increasing health literacy and providing price and quality transparency;
- Improve access to health care services;
- Encourage quality, continuity and appropriateness of medical care;
- Deliver coverage cost-effectively;
- Identify Medically Frail members and provide effective disease management, case management and care management programs for those that would benefit from such

[1]The enrollment figures provided in this Scope of Work were current as of January 2020. Enrollment in the HIP program may increase or decrease based upon federal policies, program priorities, available funding, etc.

services;

- Coordinate health and social services;
- Integrate physical and behavioral health services;
- Develop innovative member and provider incentives;
- Use technology to ease administrative burden and help accomplish program goals;
- Develop innovative utilization management techniques that incorporate member and provider education to facilitate the right care, at the right time, in the right location;
- Emphasize communication, training and collaboration with network providers; and
- Engage in provider and member outreach regarding preventive care, wellness and a holistic approach.

The Healthy Indiana Plan (HIP) is a program created to provide health care coverage to low-income adults. Indiana offers HIP members a comprehensive benefit package through a high deductible health plan paired with a personal health care account called a POWER (Personal Wellness and Responsibility) Account. The health plan is subject to a $2,500 deductible and includes "first dollar" coverage for Affordable Care Act (ACA) required preventive services. Services considered preventive but not required by the ACA may be provided at $500 first dollar coverage per year. For purposes of clarification, MCEs may cap first dollar preventive services at $500 per year but shall provide all required ACA preventive services first dollar as required by the ACA. The preventive services benefit is designed to help eliminate barriers to obtaining preventive care. Indiana offers HIP members comprehensive benefits in several benefit packages (HIP Plus, HIP Basic, HIP State Plan, and HIP Maternity) as described in Section 3.0 and Section 12.0. A description of the HIP covered services is set forth in Exhibit 3.B of the Contract.

The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and is funded with state and individual contributions. Employers and other third parties may also contribute.

Members use POWER Account funds to meet the $2,500 deductible. POWER Accounts are funded with post-tax dollars and are not considered HSAs or other health spending accounts (e.g., Flexible Spending Accounts, Health Reimbursement Accounts, etc.) under federal law. Therefore, they are not subject to regulation under the U.S. Tax Code as such.

Members who consistently make required contributions to their POWER account will maintain access to the "HIP Plus" benefit plan that includes enhanced benefits such as dental, vision, and chiropractic manipulation coverage.

Members with income at or below one hundred percent (100%) of the federal poverty level (FPL)[2] who do not to make monthly POWER account contributions will be placed in the "HIP Basic" plan, a more limited benefit plan. The HIP Basic plan maintains essential benefits but incorporates reduced benefit coverage and a more limited pharmacy benefit. The HIP Basic plan will require co-payments for most services rather than the monthly POWER account contributions required of the HIP Plus plan. Except in limited circumstances, members with income above 100% FPL will not have access to the HIP Basic plan but will instead be terminated from the program.

[2] All federal poverty levels listed in this Scope of Work are calculated based on the Modified Adjusted Gross Income (MAGI), which allows for a five percent (5%) income disregard.

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Contractor shall ensure that they follow all program requirements as described in the HIP MCE Policies and Procedures Manual as updated and amended periodically.

2.0 Administrative Requirements

2.1 State Licensure and Compliance with Applicable Laws, Rules, and Regulations

Prior to the Contract effective date, and as verified in the readiness review, the Contractor shall be:

- An Indiana-licensed accident or sickness insurer; or
- An Indiana-licensed health maintenance organization (HMO).

The Contractor and all subcontractors shall use clinicians licensed by Indiana and follow all requirements contained within the Contract (e.g., Prior Authorization/Utilization Management (PA/UM) criteria; claims processing; encounter data submission; etc.), regardless of geographic location.

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act of 1990 as amended; section 1557 of the Patient Protection and Affordable Care Act per 42 CFR 438.3(f)(1) and 42 CFR 438.100(d).

2.2 National Committee for Quality Assurance (NCQA) Accreditation

As required by IC 12-15-12-21, the Contractor shall be accredited by the National Committee for Quality Assurance (NCQA) on or before the Contract start date. When accreditation standards conflict with the standards set forth in the Contract, the Contract prevails, unless the accreditation standard is more stringent.

Per 42 CFR 438.332(b), the Contractor must authorize NCQA to provide the State a copy of its most recent accreditation review including: its accreditation status, survey type, and level (as applicable); recommended actions or improvements, corrective action plans, and summaries of findings; and the expiration date of the accreditation.

2.3 Administrative and Organizational Structure

The Contractor shall maintain an administrative and organizational structure that supports effective and efficient delivery of integrated services to all members in a family. The organizational structure shall demonstrate a coordinated approach to managing the delivery of health care services to its HIP populations. The Contractor's organizational structure shall support collection and integration of data from every aspect of its delivery system and its internal functional units to accurately report the Contractor's performance. The Contractor shall also have policies and procedures in place that support the integration of financial and performance data and comply with all applicable federal and state requirements.

Prior to the Contract effective date, FSSA will provide a series of orientation sessions to assist the Contractor in developing its internal operations to support the requirements of the Contract (i.e., data submission, data transmissions, reporting formats, etc.).

The Contractor shall have in place sufficient administrative and clinical staff and organizational components to comply with all HIP program requirements and standards.

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The Contractor shall not be located outside of the United States per 42 CFR 438.602(i). The Contractor shall manage the functional linkage of the following major operational areas:

- Administrative and fiscal management
- Member services
- Provider services
- Marketing
- Provider enrollment
- Network development and management
- Quality management and improvement
- Utilization management
- Clinical assessment, disease management, care management and complex case management
- Special investigations and waste, fraud and abuse detection
- Behavioral and physical health
- POWER Account administration
- POWER Account contribution collections
- Information systems
- Performance data reporting and encounter claims submission
- Claims payments
- Grievances and appeals
- Pharmacy Benefits Management

2.3.1 Staffing

The Contractor shall have in place sufficient administrative, clinical staff and organizational components to comply with all program requirements and standards. The Contractor shall maintain a high level of Contract performance and data reporting capabilities regardless of staff vacancies or turnover. The Contractor shall have an effective method to address and minimize staff turnover (e.g., cross training, use of temporary staff or consultants, etc.) as well as processes to solicit staff feedback to improve the work environment. These processes will be verified during the readiness review.

The Contractor shall have position descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to: education (e.g., high school, college degree or graduate degree), professional credentials (e.g., licensure or certifications), work experience, membership in professional or community associations, etc.

2.3.2 Key Staff

The Contractor shall employ the key staff members listed below. The State requires the Contractor to have particular key staff members dedicated full-time to the Contractor's Indiana Medicaid product lines. Contractor shall employ sufficient staff to achieve compliance with contractual requirements and performance metrics.

The Contractor shall set up and maintain a business office or work site within five miles of downtown Indianapolis, IN, from which, at a minimum, key staff members physically perform the majority of their daily duties and responsibilities, and a major portion of the Contractor's operations take place. The Contractor shall be responsible for all costs related to securing and maintaining the facility for interim start-up support and the subsequent operational facility.

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Upon award of the Contract, the Contractor shall deliver the final staffing plan within thirty (30) calendar days after notice of award; such plan will include a resume for each proposed key staff person outlined below for acceptance by FSSA. Per 42 CFR 455.104(b)(4), the Contractor shall submit the name, address, date of birth, and SSN of any managing employee of the Contractor. FSSA reserves the right to approve or disapprove all initial and replacement key staff prior to their assignment to the Healthy Indiana Program. FSSA shall have the right to require that the Contractor remove any individual (whether or not key staff) from assignment to the program.

The Contractor shall ensure the location of any staff or operational functions outside of the State of Indiana does not compromise the delivery of integrated services and the seamless experience for members and providers. The Contractor shall be responsible for ensuring all staff functions conducted outside of the State of Indiana are readily reportable to FSSA at all times to ensure such locations do not hinder the State's ability to monitor the Contractor's performance and compliance with Contract requirements. Indiana-based staff shall maintain a full understanding of the operations conducted outside of the State of Indiana, and shall be prepared to discuss these operations with FSSA upon request, including during unannounced FSSA site visits.

Except in the circumstance of the unforeseeable loss of a key staff member's services, the Contractor shall provide written notification to FSSA of anticipated vacancies of key staff within five (5) business days of receiving the key staff person's notice to terminate employment or five (5) business days before the vacancy occurs, whichever occurs first. At that time, the Contractor shall present FSSA with an interim plan to cover the responsibilities created by the key staff vacancy. Likewise, the Contractor shall notify FSSA in writing within five (5) business days after a candidate's acceptance to fill a key staff position or five (5) business days prior to the candidate's start date, whichever occurs first.

In addition to attendance at vendor meetings, all key staff shall be accessible to FSSA and its other program subcontractors via telephone, voicemail and electronic mail systems. As part of its annual and quarterly reporting, the Contractor shall submit to FSSA an updated organizational chart including e-mail addresses and phone numbers for key staff.

FSSA reserves the right to approve or deny the individuals filling the key staff positions set forth below. FSSA also reserves the right to require a change in key staff as part of a corrective action plan should performance concerns be identified.

The key staff positions required under the Contract include:

Chief Executive Officer, President, or Executive Director – The Chief Executive Officer or Executive Director has full and final responsibility for plan management and compliance with all provisions of the Contract.

Chief Financial Officer – The Chief Financial Officer shall oversee the budget and accounting systems of the Contractor for the HIP program. This Officer shall, at a minimum, be responsible for ensuring that the Contractor meets the State's requirements for financial performance and reporting.

Compliance Officer – The Contractor shall employ a Compliance Officer who is accountable to the Contractor's executive leadership and dedicated full-time to the Contractor's Healthy Indiana Plan product line. This individual will be the primary liaison with the State (or its designees) to facilitate communications between FSSA,

the State's contractors and the Contractor's executive leadership and staff. This individual shall maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the HIP program. It is the responsibility of the Compliance Officer to coordinate reporting to the State as defined in Section 9.0 and to review the timeliness, accuracy and completeness of reports and data submissions to the State. The Compliance Officer, in close coordination with other key staff, has primary responsibility for developing and implementing policies, procedures, and practices designed to ensure all Contractor functions are in compliance with the terms of the Contract. The Compliance Officer shall meet with the OMPP Program Integrity Unit on a quarterly basis.

Chief Information Officer (CIO) or Information Technology (IT) Director – The Contractor shall employ a CIO or IT Director who is dedicated full-time to the Contractor's Indiana Medicaid product lines. This individual will oversee the Contractor's HIP Information Technology (IT) systems and serve as a liaison between the Contractor and the State fiscal agent or other FSSA contractors regarding encounter claims submissions, capitation payment, member eligibility, POWER Account administration, enrollment and other data transmission interface and management issues. The CIO or IT Director, in close coordination with other key staff, is responsible for ensuring all program data transactions are in compliance with the terms of the Contract. The CIO or IT Director is responsible for attendance at all Technical Meetings called by the State. If the CIO or IT Director is unable to attend a Technical Meeting, the CIO or IT Director shall designate a representative to take his or her place. This representative shall report back to the CIO or IT Director on the Technical Meeting's agenda and action items. For more information on the IT program requirements, see Section 8.0.

Medical Director – The Contractor shall employ the services of a Medical Director who is an Indiana-licensed Health Care Provider (IHCP) provider board certified in family medicine or internal medicine. If the Medical Director is not board certified in family medicine, they shall be supported by an Indiana-licensed clinical team with experience in pediatrics, behavioral health, adult medicine and obstetrics/gynecology. The Medical Director shall be dedicated full-time to the Contractor's Indiana Medicaid product lines. The Medical Director shall oversee the development and implementation of the Contractor's disease management, case management and care management programs; oversee the development of the Contractor's clinical practice guidelines; review any potential quality of care problems; oversee the Contractor's clinical management program and programs that address special needs populations; oversee health screenings and medically frail assessments; serve as the Contractor's medical professional interface with the Contractor's primary medical providers (PMPs) and specialty providers; and direct the Quality Improvement and Utilization Management programs, including, but not limited to, monitoring, corrective actions and other quality improvement activities, utilization management or program integrity activities. The Medical Director, in close coordination with other key staff, is responsible for ensuring that the medical management and quality improvement components of the Contractor's operations are in compliance with the terms of the Contract. The Medical Director shall work closely with the Pharmacy Director to ensure compliance with pharmacy-related responsibilities set forth in Section 3.4. The Medical Director shall attend all FSSA quality meetings, including the Quality Strategy Committee meetings and Subcommittee meetings. If the Medical Director is unable to attend an FSSA quality meeting, the Medical Director shall designate a representative to take their place. This representative must report back to the Medical Director on the meeting's agenda and action items. The Medical Director shall be responsible for knowing and taking appropriate action on all agenda and action items from all FSSA quality meetings.

EXHIBIT 1B

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Member Services Manager – The Contractor shall employ a Member Services Manager who is dedicated full-time to member services for the Contractor's Healthy Indiana Plan product line, which shall be available via the member helpline and the member website, including through a member portal. The Member Services Manager shall, at a minimum, be responsible for directing the activities of the Contractor's member services, including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval and distribution of member materials and employer outreach for HIP members. The Member Services Manager manages the member grievances and appeals process, and works closely with other managers (especially, the Quality Improvement Manager, Utilization Manager and Medical Director) and departments to address and resolve member grievances and appeals. The Member Services Manager shall oversee the interface with the Enrollment Broker regarding such issues as member enrollment and disenrollment, member PMP assignments and changes, member eligibility and newborn enrollment activities The Member Services Manager shall provide an orientation and on-going training for member services helpline representatives, at a minimum, to support accurately informing members of how the Contractor operates, availability of covered services, benefit plans and limitations, health screenings, emergency services, PMP assignment and changes, specialty provider referrals, self-referral services, preventive and enhanced services, POWER Account services, and member grievances and appeals procedures. The Member Services Manager, in close coordination with other key staff, is responsible for ensuring that all of the Contractor's member services operations are in compliance with the terms of the Contract. For more information regarding the member services program requirements, see Section 4.0.

Provider Services Manager – The Contractor shall employ a Provider Services Manager who is dedicated full-time to the Contractor's Healthy Indiana Plan product. The Provider Services Manager shall, at a minimum, be responsible for the provider services helpline performance, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials and developing outreach programs. The Provider Services Manager oversees the process of providing information to the State fiscal agent regarding the Contractor's provider network. The Provider Services Manager, in close coordination with other key staff, is responsible for ensuring that all of the Contractor's provider services operations are in compliance with the terms of the Contract. For more information regarding the provider services program requirements, see Section 5.0.

Special Investigation Unit Manager – The Contractor shall employ a Special Investigation Unit (SIU) Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The SIU Manager shall be located in Indiana. The SIU Manager is responsible for directing the activities of Special Investigation Unit staff, attending meetings with FSSA and reducing or eliminating wasteful, fraudulent, or abusive healthcare billings and services. It is the responsibility of the SIU Manager to coordinate the timeliness, accuracy and completeness of all suspected or confirmed instances of waste, fraud and abuse referrals to the OMPP Program Integrity (OMPP PI) Section. The SIU Manager shall report to the Compliance Officer and meet with the OMPP PI Section at a minimum of quarterly or more frequently as directed by the OMPP PI Section. The SIU Manager shall be a subject matter expert in Medicaid program integrity and hold qualifications similar to those of state program integrity section managers.

Quality Improvement Manager – The Contractor shall employ a Quality

Improvement Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The Quality Improvement Manager shall, at a minimum, be responsible for directing the activities of the Contractor's quality improvement staff in monitoring and auditing the Contractor's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Quality Improvement Manager shall assist the Contractor's Compliance Officer in overseeing the activities of the Contractor's operations to meet the State's goal of providing health care services that improve the health status and health outcomes of HIP members. For more information regarding the quality management requirements, see Section 6.0.

Utilization Management Manager – The Contractor shall employ a Utilization Management Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The Utilization Management Manager shall, at a minimum, be responsible for directing the activities of the utilization management staff. With direct supervision by the Medical Director, the Utilization Management Manager shall direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, appropriate utilization of health care services, continuity of care, care coordination and other clinical and medical management programs. The Utilization Management Manager shall work with the Special Investigation Unit (SIU) Manager to assure that service billing and utilization issues are documented and reported to the SIU, and matters requiring SIU review or investigation shall be timely submitted within five (5) business days to enable recovery of overpayments or other appropriate action. For more information regarding the utilization management requirements, see Section 6.3.

Behavioral Health Manager – The Contractor shall employ a Behavioral Health Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The Behavioral Health Manager is responsible for ensuring that the Contractor's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager shall coordinate with all functional areas, including quality improvement, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance and reporting. The Behavioral Health Manager shall fully participate in all quality management and improvement activities, including participating in Quality Strategy Committee meetings and in the Mental Health Quality Assurance Committee. The Behavioral Health Manager shall work closely with the Contractor's network development and provider relations staff to develop and maintain the behavioral health network and ensure that it is fully integrated with the physical health provider network. The Behavioral Health Manager shall collaborate with key staff to ensure the coordination of physical and behavioral health care as set forth in Section 3.7 and coordination with Medicaid Rehabilitation Option (MRO) and 1915(i) services as set forth in Sections 3.11.1 and 3.11.2. The Behavioral Health Manager shall work closely with the utilization management staff to monitor behavioral health utilization, especially to identify and address potential behavioral health under- or over-utilization. The Behavioral Health Manager or designee shall be the primary liaison with behavioral health community resources, including Community Mental Health Centers (CMHCs), and be responsible for all reporting related to the Contractor's provision of behavioral health services. The Behavioral Health Manager shall work closely with the Medical Director and Transition Coordination Manager to appropriately identify medically frail HIP members and ensure access to appropriate behavioral health services.

If the Contractor subcontracts with a behavioral health organization (BHO) to provide

behavioral health services, the Behavioral Health Manager will continue to work closely with the Contractor's other managers to provide monitoring and oversight of the BHO and to ensure the BHO's compliance with the Contract. (See Section 2.6 regarding requirements for FSSA's approval of subcontractors.)

Dental Manager – The Contractor must employ an Indiana Dentist as a Dental Manager who is dedicated to Indiana Medicaid. This individual, in coordination with the Medical Director, is responsible for ensuring the dental benefit operated by the Contractor or subcontractor is compliant with standards of dental care and consistent with this Contract. The Dental Manager establishes and coordinates with implementation of the Contractor's oral health strategy to ensure comprehensive, whole person health.

Data Compliance Manager – The Contractor shall employ a Data Compliance Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The Data Compliance Manager will provide oversight to ensure the Contractor's HIP data conform to FSSA and OMPP data standards and policies. The Data Compliance Manager shall have extensive experience in managing data quality and data exchange processes, including data integration and data verification. The Data Compliance Manager shall also be knowledgeable in health care data and health care data exchange standards. The Data Compliance Manager will manage data quality, change management and data exchanges with FSSA, OMPP or its designee(s). The Data Compliance Manager shall be responsible for data quality and verification, data delivery, change management processes used for data extract corrections and modification and enforcement of data standards and policies for data exchanges to FSSA & OMPP as defined by the State. The Data Compliance Manager shall coordinate with the State to implement data exchange requirements.

Pharmacy Director – The Contractor shall employ a Pharmacy Director who is an Indiana licensed pharmacist dedicated full-time to the Contractor's Indiana Medicaid product lines. The Pharmacy Director shall oversee all pharmacy benefits under this Contract as outlined in Section 3.4. This individual shall represent the Contractor at all meetings of the State's Drug Utilization Review (DUR) Board meetings and the Mental Health Quality Assurance Advisory Committee (MHQAC). If the Contractor subcontracts with a Pharmacy Benefits Manager (PBM) for its Healthy Indiana Plan pharmaceutical services, the Pharmacy Director shall be responsible for oversight and Contract compliance of the PBM, including pharmacy audits, as well as any audits or other responses.

POWER Account Operations Manager – The Contractor shall employ a POWER Account Operations Manager who is dedicated full-time to the HIP program's POWER Account financial transaction operations. The POWER Account Operations Manager shall be responsible for overseeing the accurate and efficient administration of member POWER Accounts, as outlined in the HIP MCE Policies and Procedures Manual, including but not limited to: POWER Account contribution billing, reminders and collections; applying member, state, third party and employer contributions to the POWER Account; member termination or transfer to HIP Basic, as applicable, for non-payment; Power Account Reconciliation files (PRFs); POWER Account statements; POWER Account reconciliation and rollover; POWER Account contribution recalculations; POWER Account transfers; and POWER Account reporting. This individual shall be responsible for ensuring compliance with the terms of this Contract and all POWER Account policies and procedures as outlined in the POWER Account technical requirements and the HIP MCE Policies and Procedures Manual.

EXHIBIT 1B

SCOPE OF WORK – HEALTHY INDIANA PLAN

Transition Coordination Manager – The Contractor shall employ a full-time Transition Coordination Manager dedicated to member transitions, including, transitions in and out of the various HIP benefit plans, including HIP Maternity coverage, as well as member transitions in and out of the Contractor's enrollment. The Transition Coordination Manager will also oversee transitions related to members identified as medically frail and members referred to the Right Choices Program. This Manager will work closely with the Medical Director, Behavioral Health Manager, Provider and Members Services Managers, POWER Account Operations Manager and State staff as necessary to manage member transitions and ensure effective communication to providers and members, as well as the State and its contractors. The Transition Coordination Manager will provide input, as requested by the State, at State level meetings.

Member Advocate/Non-Discrimination Coordinator – The Contractor must employ a Member Advocate/Non-Discrimination Coordinator dedicated full-time to the Healthy Indiana Plan program who is responsible for representation of members' interests including input in policy development, planning and decision-making. The Member Advocate shall be responsible for development and oversight of the Member Advisory Committee. This individual shall also be responsible for the Contractor's compliance with federal and state civil rights laws, regulations, rules and policies, including but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) and the Age Discrimination Act.

Grievance and Appeals Manager – The Contractor shall employ a dedicated Grievance and Appeals Manager responsible for managing the Contractor's HIP grievance and appeals process. This individual shall be responsible for ensuring compliance with processing timelines and policy and procedure adherence as outlined in Section 4.9. The Grievance and Appeals Manager will ensure the Contractor has appropriate representation and/or provides adequate documentation in the event that a member appeals to the State.

Claims Manager – The Contractor shall employ a Claims Manager dedicated full-time to the Contractor's Indiana Medicaid product lines and responsible for ensuring prompt and accurate provider claims processing in accordance with the terms of the Contract. This individual shall work in collaboration with the CIO or IT Director to ensure the timely and accurate submission of encounter data as delineated in Section 8.6. The Claims Manager (or Utilization Management Manager, as applicable) shall work with the Special Investigation Unit (SIU) Manager to assure that service billing and utilization issues are documented and reported to the SIU, and matters requiring SIU review or investigation shall be timely submitted within (5) business days to enable recovery of overpayment or other appropriate action.

Care Management Manager – The Contractor must employ a full-time Care Management Manager dedicated to the Healthy Indiana Plan program. This Manager must oversee the disease management, care management, complex case management and Right Choices Program (RCP) functions as outlined in Section 3.8. The Care Management Manager must, at a minimum, be a registered nurse or other medical professional with extensive experience in providing care coordination to a variety of populations. This individual will work directly under the Contractor's Medical Director to develop, expand and maintain the care management program. The individual will be responsible for overseeing care management teams, care plan development and care plan implementation. The Care Management Manager will be responsible for directing the activities of the care managers. These responsibilities extend to physical and behavioral health care services. This individual will work with

the Medical Director, Provider and Member Services Managers, and with State staff as necessary, to communicate to providers and members. The Care Management Manager will provide input, as requested by the State, at State-level meetings.

Equity Officer – The Contractor must employ a full-time Equity Officer dedicated to the Contractor's Indiana Medicaid product lines. The Equity Officer will provide leadership and management to define, implement, and evaluate strategies to achieve equitable access and reduce disparities in clinical care and quality outcomes. This strategy must include tracking, assessing, and improving disparities in care, and supporting the diverse cultural, language, disability, economic, education and health status needs of those served by the Contractor.

2.3.3 Other Required Staff Positions

In addition to the required key staff described in Section 2.3.2, the Contractor shall employ those additional staff necessary to ensure the Contractor's compliance with the State's performance requirements. Required staff includes but are not limited to:

Grievance and appeals staff necessary to investigate and coordinate responses to address member and provider grievances and appeals against the Contractor and interface with the FSSA and the Indiana Office of Administrative Law Proceedings.

Technical support services staff to ensure the timely and efficient maintenance of information technology support services, production of reports, processing of data requests and submission of encounter data.

Quality improvement staff dedicated to perform quality management and improvement activities, and participate in the Contractor's internal Quality Assessment and Performance Improvement Committee.

Utilization and medical management staff dedicated to perform utilization management and review activities.

Case managers who provide case management, care management, care coordination and utilization management for high-risk or high-cost members receiving physical health and/or behavioral health services. The case managers identify the needs and risks of the Contractor's membership, including social barriers; serve as a coordinator to link members to services; and ensure that members receive the appropriate care in the appropriate setting by the appropriate providers.

Board certified psychiatrist and addiction specialist part-time or on-call board certified psychiatrist and addiction specialist with qualifications and certification as outlined by ASAM for behavioral health utilization management activities.

Member services representatives to coordinate communications between the Contractor and its members; respond to member inquiries; and assist all members regarding issues such as the Contractor's policies, procedures, general operations, benefit coverage and eligibility. Member services staff should have access to real time data on members, including eligibility status, benefit package, POWER Account contributions, balance and transactions, PMP assignments and all service and utilization data. Member services staff shall have the appropriate training and demonstrate full competency before interacting with members.

Member marketing and outreach staff to manage joint marketing and outreach efforts for the HIP program.

Compliance staff to support the Compliance Officer and help ensure all Contractor functions are in compliance with state and federal laws and regulations, the State's policies and procedures and the terms of the Contract.

Provider representatives to develop the Contractor's network and coordinate communications between the Contractor and contracted and non-contracted providers, paying particular attention to educating and encouraging providers to participate in the HIP program and other Indiana Medicaid product lines to ensure continuity of care for members transitioning between programs.

Claims processors to process electronic and paper claims in a timely and accurate manner, process claims correction letters, process claims resubmissions and address overall disposition of all claims for the Contractor, per state and federal guidelines, as well as a sufficient number of staff to ensure the submission of timely, complete and accurate encounter claims data.

Member and provider education/outreach staff to promote health-related prevention and wellness education and programs; maintain member and provider awareness of the Contractor's programs, policies and procedures; and identify and address barriers to an effective health care delivery system for the Contractor's members and providers.

Special Investigation Unit staff to support the Special Investigation Unit Manager and help review and investigate Contractor's providers and members that are engaging in wasteful, abusive, or fraudulent billing or service utilization. The SIU shall have, at a minimum, one full-time, dedicated staff member for every 100,000 members, excluding the SIU Manager. Accordingly, for example, plans servicing 360,000 members shall have a Special Investigation Unit Manager and 3.6 FTE additional staff. A majority of SIU staff including the SIU Manager shall work in Indiana to enable sufficient onsite audit capability and facilitate in-person meeting attendance as directed by FSSA.

Website staff to maintain and update the Contractor's member and provider websites and member portal.

POWER Account collection staff to support the Contractor's HIP POWER Account operations and POWER Account contribution billing, collections and reconciliation.

Transition Coordination staff to support the Transition Coordination Manager in the oversight of all member transitions in and out of the various benefit plans available in the Contractor's Indiana Medicaid programs, as well as in an out of the Contractor's enrollment. The Transition Coordination staff shall be responsible for ensuring continuity of care, member and provider communication, and POWER Account reconciliation through all benefit plan and MCE transfers. The Transition Coordinator shall be responsible for ensuring the transfer and receipt of all outstanding prior authorization decisions, utilization management data and clinical information such as disease management, care management and complex case management notes.

2.3.4 Suggested Staff Positions

The Contractor is responsible for ensuring adequate staffing to meet the requirements of the Contract and the delivery of high quality, operationally efficient services. FSSA may set required staffing levels for contractors. FSAA may require additional staffing for Contractors who fail to maintain compliance with the performance metrics of the Contract. Suggested staffing includes, but is not limited

to those listed below. The Contractor shall adhere to the State approved staffing plan.

- Executive management to interface with FSSA leadership to coordinate and confer with the State on matters related to the Contractor's participation in the HIP program.

- Technical support services staff to ensure the timely and efficient maintenance of information technology support services, production of reports and processing of data requests and submission of encounter data.

- Quality management improvement staff dedicated to perform quality management and improvement activities, and participate in the Contractor's internal Quality Management and Improvement Committee.

- Utilization and medical management staff dedicated to perform utilization management and review activities.

- Member services representatives to coordinate communications between the Contractor and its members, respond to member inquiries, and assist all members regarding issues such as the Contractor's policies, procedures, general operations, benefit coverage and eligibility. Member services staff should have access to real time data on members, including, but not limited to, eligibility status and all service and utilization data. Member services staff must have the appropriate training and demonstrate full competency before interacting with members.

- Member marketing and outreach staff to manage marketing and outreach efforts for the HIP program.

- Compliance staff to support the Compliance Officer and help ensure all Contractor functions are in compliance with state and federal laws and regulations, the State's policies and procedures and the terms of the Contract.

- Provider representatives to develop the Contractor's network and coordinate communications between the Contractor and contracted and non-contracted providers.

- Claims processors to process electronic and paper claims in a timely and accurate manner, process claims correction letters, process claims resubmissions and address overall disposition of all claims for the Contractor, per state and federal guidelines.

- A sufficient number of staff to ensure the submission of timely, complete and accurate encounter claims data.

- Member and provider education/outreach staff to promote health-related and preventive care education and programs, maintain member and provider awareness of the Contractor's policies and procedures, and identify and address barriers to an effective health care delivery system for the Contractor's members and providers.

- Website staff to maintain and update the Contractor's member and provider websites.

2.3.5 Staff Training and Qualifications

On an ongoing basis, the Contractor shall ensure that each staff person, including members of subcontractors' staff, has appropriate education and experience to fulfill the requirements of their position, as well as ongoing training (e.g., orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, management of IT systems, training on fraud and abuse and the False Claims Act, HIPAA, etc.). The Contractor shall provide initial and ongoing training and must ensure all staff are trained in the major components of the HIP program. Staff training shall include, but is not limited to:

- An overview of the HIP program & associated policies and procedures, including updates whenever changes occur;
- Contract requirements and state and federal requirements specific to job functions;
- In accordance with 42 CFR 422.128(b)(1)(ii)(H), 42 CFR 489.102(a)(5), and 42 CFR 438.3(j), training on the Contractor's policies and procedures on advance directives;
- Initial and ongoing training on identifying and handling quality of care concerns;
- Cultural sensitivity training;
- Training on fraud and abuse and the False Claims Act;
- Health Insurance Portability and Accountability Act (HIPAA) training;
- Management of IT systems;
- Clinical protocol training for all clinical staff;
- Utilization management staff shall receive ongoing training regarding interpretation and application of the Contractor's utilization management guidelines. The ongoing training shall, at minimum, be conducted on a quarterly basis and as changes to the Contractor's utilization management guidelines and policies and procedures occur;
- Assessment processes, person-centered planning and population specific training relevant to the populations enrolled in the HIP program for all care managers. The Contractor shall also ensure all applicable subcontractors provide such training to their relevant staff;
- Training and education to understand abuse, neglect, exploitation and prevention including the detection, reporting, investigation and remediation procedures and requirements;
- Training for transportation, prior authorization and member services staff on the geography of the state and location of network service providers to facilitate the approval of services and recommended providers in the most geographically appropriate location; and

- Staff members with POWER Account responsibilities shall receive detailed POWER Account education and training on topics including but not limited to: financial transactions, billing and collections, POWER Account contribution recalculations, the impact of benefit plan transfers on the POWER Account, POWER Account rollover, POWER Account termination and the POWER Account Reconciliation File (PRF), 820 and 834 transactions.

The State-developed HIP MCE Policies and Procedures Manual, as may be amended by FSSA from time to time, shall be provided to the Contractor's entire staff and shall be incorporated into all training programs for staff responsible for providing services under the Contract. Training materials must be updated on a regular basis to reflect any program changes. The Contractor shall maintain documentation to confirm staff training, curriculum, schedules and attendance, and provide to FSSA upon request and during regular on-site visits. For its utilization management and POWER Account training activities in particular, the Contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by FSSA.

2.3.6 Debarred Individuals

In accordance with 42 CFR 438.610, section 1932(d)(1) of the Social Security Act, SMDL 6/12/08 and SMDL 1/16/09, which prohibits affiliations with individuals debarred by Federal agencies, the Contractor shall not knowingly have a relationship with the following:

- An individual or entity who is (or is affiliated with a person/entity that is) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, which relates to debarment and suspension

- An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above; or

- An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

The relationships include directors, officers or partners of the Contractor, persons with beneficial ownership of five percent (5%) or more of the Contractor's equity, network providers, subcontractors, or persons with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

In accordance with section 1932(d)(1) of the Social Security Act, 42 CFR 438.608(c)(1), 42 CFR 438.610(a), 42 CFR 438.610(b), 42 CFR 438.610(c), SMDL 6/12/08, SMDL 1/16/09, and Exec. Order No. 2549, the Contractor shall provide written disclosure of any of the prohibited relationships described above. If FSSA finds that the Contractor is in violation of these regulations, FSSA will notify the Secretary of noncompliance and determine if this Contract will be continued or terminated in accordance with 42 CFR 438.610(d).

The Contractor must have policies and procedures in place to routinely monitor staff positions and subcontractors for individuals debarred or excluded. As part of readiness review, the Contractor must demonstrate to FSSA that it has mechanisms

in place to monitor staff and subcontractors for individuals debarred by Federal agencies.

The Contractor is required to disclose to the OMPP Program Integrity Unit information required by 42 CFR 455.106 regarding the Contractor's staff and person with an ownership/controlling interest in the Contractor that have been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid or Title XX programs.

2.4 FSSA Meeting Requirements

FSSA conducts meetings and collaborative workgroups for the HIP program. The Contractor shall comply with all meeting requirements established by FSSA and is expected to cooperate with FSSA and/or its contractors in preparing for and participating in these meetings. FSSA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary.

The Contractor shall also participate in meetings and proceedings with external entities as directed by FSSA, including but not limited to, the DUR Board, MHQAC, Medicaid Advisory Committee, Therapeutics Committee, Indiana Psychotropic Medication Advisory Committee and legislative hearings. FSSA may also require the participation of subcontracted entities in other instances, as determined necessary. Attendance at all meetings shall be at no additional cost to FSSA. FSSA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary.

At Contract initiation, FSSA will conduct a series of orientation sessions. The Contractor shall ensure the attendance of appropriate staff at each session based on topics to be discussed. During Contract implementation, the Contractor shall meet with FSSA on a State approved schedule to coordinate a smooth transition and implementation. The Contractor should be prepared to meet weekly.

FSSA reserves the right to meet at least annually with the Contractor's executive leadership to review the Contractor's performance, discuss the Contractor's outstanding or commendable contributions, identify areas for improvement and outline upcoming issues that may impact the Contractor or the HIP program.

2.5 Financial Stability

The Contractor shall meet and comply with all requirements located in Title 27, Articles 1 through 15, of the Indiana Code. This includes, but is not limited to, the requirements pertaining to financial solvency, reinsurance and policy contracts, as well as administration of these processes.

FSSA and the Indiana Department of Insurance (IDOI) will monitor the Contractor's financial performance. FSSA will include IDOI findings in their monitoring activities. FSSA shall be copied on required filings with IDOI, and the required filings shall break out financial information for the HIP lines of business separately. The financial performance reporting requirements are listed in Section 9.1 and are further described in the HIP MCE Reporting Manuals, which shall be provided following the Contract award date.

2.5.1 Solvency

The Contractor shall maintain a fiscally solvent operation per federal regulations and

IDOI's requirements for a minimum net worth and risk-based capital. The Contractor shall have a process in place to review and authorize contracts established for reinsurance and third-party liability, if applicable.

The Contractor shall comply with the federal requirements for protection against insolvency pursuant to 42 CFR 438.116, which sets solvency standards for managed care entities. Per 42 CFR 438.604(a)(4), 42 CFR 438.606, and 42 CFR 438.116, the Contractor shall submit documentation on the basis of which the State determines that the Contractor has made adequate provision against the risk of insolvency.

These requirements provide that, unless the Contractor is a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act), the Contractor shall:

- Provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its members will not be liable for the Contractor's debts if the entity becomes insolvent per 42 CFR 438.106(a) and section 1932(b)(6) of the Social Security Act.

- Meet the solvency standards established by the State for private health maintenance organizations or be licensed or certified by the State as a risk-bearing entity per 42 CFR 438.116(b) and section 1903(m)(1) of the Social Security Act.

Also, see Section 2.5.2 below.

2.5.2 Insurance Requirements

The Contractor shall be in compliance with all applicable insurance laws of the State of Indiana and the federal government throughout the term of the Contract. No less than ninety (90) calendar days prior to delivering services under the Contract, the Contractor shall obtain Fidelity Bond or Fidelity Insurance, as defined in IC 27-13-5-2, from an insurance company duly authorized to do business in the State of Indiana.

No less than thirty (30) calendar days before the policy renewal effective date, the Contractor shall submit to FSSA its certificate of insurance for each renewal period for review and approval.

2.5.3 Reinsurance

The Contractor shall purchase reinsurance from a commercial reinsurer and shall establish reinsurance agreements meeting the requirements listed below. The Contractor shall submit new policies, renewals or amendments to FSSA for review and approval at least one hundred and twenty (120) calendar days before becoming effective.

- Agreements and Coverage

    - The attachment point shall be equal to or less than $500,000 and shall apply to all services, unless otherwise approved by FSSA. The Contractor electing to establish commercial reinsurance agreements with an attachment point greater than $500,000 shall provide a justification in its proposal or submit justification to FSSA in writing at least one hundred and twenty (120) calendar days prior to the policy renewal date or date of the proposed change. The Contractor shall receive approval from FSSA before changing the attachment point.

- The Contractor's co-insurance responsibilities above the attachment point shall be no greater than twenty percent (20%).
- Reinsurance agreements shall transfer risk from the Contractor to the reinsurer.
- The reinsurer's payment to the Contractor shall depend on and vary directly with the amount and timing of claims settled under the reinsured contract. Contractual features that delay timely reimbursement are not acceptable.
- The Contractor shall obtain continuation of coverage insurance (insolvency insurance) to continue plan benefits for members until the end of the period for which premiums have been paid. This coverage shall extend to members in acute care hospitals or nursing facility settings when the Contractor's insolvency occurs during the member's inpatient stay. The Contractor shall continue to reimburse for its member's care under those circumstances (i.e., inpatient stays) until the member is discharged from the acute care setting or nursing facility.

▪ Requirements for Reinsurance Companies

- The Contractor shall submit documentation that the reinsurer follows the National Association of Insurance Commissioners' (NAIC) Reinsurance Accounting Standards.
- The Contractor is required to obtain reinsurance from insurance organizations that have Standard and Poor's claims-paying ability ratings of "AA" or higher and a Moody's bond rating of "A1" or higher, unless otherwise approved by FSSA.

▪ Subcontractors

- Subcontractors' reinsurance coverage requirements shall be clearly defined in the reinsurance agreement.
- Subcontractors should be encouraged to obtain their own stop-loss coverage with the above-mentioned terms.
- If subcontractors do not obtain reinsurance on their own, the Contractor is required to forward appropriate recoveries from stop-loss coverage to applicable subcontractors.

2.5.4 Financial Accounting Requirements

The Contractor shall maintain separate accounting records for the HIP lines of business that incorporate performance and financial data of subcontractors, as appropriate, particularly risk-bearing subcontractors. The Contractor's accounting records shall be maintained in accordance with the IDOI requirements. If the Contractor does not provide HIP-specific information, FSSA may terminate the Contract. The Contractor shall provide documentation that its accounting records are compliant with IDOI standards.

The Contractor shall make full disclosure, and the State shall review, ownership and

control information for the Contractor, any subcontracting entities or providers as required by 42 CFR 455.104-106, as directed in the MCE Policies and Procedures Manual and as required by 42 CFR 438.604(a)(6), 42 CFR 438.606, 42 CFR 455.104(b), 42 CFR 438.230, and 42 CFR 438.608(c). The Contractor shall notify FSSA of any person or corporation with five percent (5%) or more of ownership or controlling interest in the Contractor and shall submit financial statements for these individuals or corporations. The Contractor shall submit the date of birth and Social Security Number (SSN) of any individual with an ownership or controlling interest in the Contractor and its subcontractors. The Contractor shall submit other tax identification number of any corporation with an ownership or controlling interest in the Contractor and any subcontractor in which the Contractor has a five percent (5%) or more controlling interest. The Contractor shall submit the name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

Annual audits shall include an actuarial opinion of the Contractor's incurred but not received claims (IBNR) specific to the HIP program.

Authorized representatives or agents of the State and the federal government shall have access to the Contractor's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit and/or reproduction. In addition, the Contractor shall file with the State Insurance Commissioner the financial and other information required by the IDOI.

Copies of any accounting records pertaining to the Contract shall be made available by the Contractor within ten (10) calendar days of receiving a written request from the State for specified records. If such original documentation is not made available as requested, the Contractor shall provide transportation, lodging and subsistence at no cost, for all state and/or federal representatives to carry out their audit functions at the principal offices of the Contractor or other locations of such records. FSSA, IDOI, OMPP and other state and federal agencies and their respective authorized representatives or agents shall have access to all accounting and financial records of any individual, partnership, firm or corporation insofar as they relate to transactions with any department, board, commission, institution or other state or federal agency connected with the Contract.

The Contractor shall maintain financial records pertaining to the Contract, including all claims records, for three (3) years following the end of the federal fiscal year during which the Contract is terminated, or when all state and federal audits of the Contract have been completed, whichever is later, in accordance with 45 CFR 75.361, which sets retention and access requirements for records. Financial records should address matters of ownership, organization and operation of the Contractor's financial, medical and other record keeping systems. However, accounting records pertaining to the Contract shall be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the Contract if the litigation has not terminated within the three (3)-year period.

In addition, FSSA requires Contractors to produce the following financial information, upon request:

- Tangible Net Equity (TNE) or Risk Based Capital at balance sheet date

- Cash and Cash Equivalents
- Claims payment, IBNR, reimbursement, fee for service claims, provider contracts by line of business
- Appropriate insurance coverage for medical malpractice, general liability, property, workmen's compensation and fidelity bond, in conformance with state and federal regulations
- Revenue Sufficiency by line of business /group
- Renewal Rates or Proposed Rates by line of business
- Corrective Action Plan Documentation and Implementation
- Financial, Cash Flow and Medical Expense Projections by line of business
- Underwriting Plan and Policy by line of business
- Premium Receivable Analysis by line of business
- Affiliate and Inter-company Receivables
- Current Liability Payables by line of business
- Medical Liabilities by line of business
- Copies of any correspondence to and from the IDOI

2.5.5 Reporting Transactions with Parties of Interest

Any Contractor that is not a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act) shall disclose to FSSA and, upon request, to certain federal agencies as described in the regulation, information on certain types of transactions they have with a "party in interest," as defined in the Public Health Service Act. (See §§1903(m)(2)(A)(viii) and 1903(m)(4) of the Social Security Act.) For purposes of this Scope of Work, the following reporting requirements will apply to all Contractors in the same manner that they apply to federally qualified HMOs under the Public Health Service Act.

Definition of a Party in Interest--As defined in §1318(b) of the Public Health Service Act, a party in interest is:

- Any director, officer, partner or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note or other interest secured by, and valuing more than five percent (5%) of the HMO; and, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;
- Any entity in which a person described in the paragraph above is director or officer; is a partner; has directly or indirectly a beneficial interest of more

than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the HMO;

- Any person directly or indirectly controlling, controlled by or under common control with a HMO; and
- Any spouse, child or parent of an individual described above.

Types of Transactions Which Shall Be Disclosed – Business transactions which shall be disclosed include:

- Any sale, exchange or lease of any property between the HMO and a party in interest;
- Any lending of money or other extension of credit between the HMO and a party in interest; and
- Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which shall be disclosed in the transactions between the Contractor and a party in interest listed above includes:

- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

In addition to the above information on business transactions, the Contractor may be required to submit a consolidated financial statement for the Contractor and the party in interest.

Per section 1903(m)(4)(B) of the Social Security Act, any reports of transactions between the Contractor and parties in interest that are provided to the State, or other agencies shall be made available to the Contractor's members upon reasonable request.

If the Contract is an initial contract with FSSA, but the Contractor has operated previously in commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed. If the Contract is being renewed or extended, the Contractor shall disclose information on business transactions which occurred during the prior contract period. The business transactions which shall be reported are not limited to transactions related to serving the Medicaid enrollment, that is, all of the Contractor's business transactions shall be reported.

2.5.6 Medical Loss Ratio

The MLR shall be calculated as follows:

EXHIBIT 1B

SCOPE OF WORK – HEALTHY INDIANA PLAN

Each reporting year, consistent with MLR standards as required in 42 CFR 438.8, the Contractor shall calculate, attest to the accuracy, and submit to FSSA its Medical Loss Ratio (MLR). For the HIP line of business, POWER Account expenditures may be included in both the numerator and denominator of the MLR calculation. The MLR submission must fully comply with 42 CFR 438.8(d)-(n) which specifies that the MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)). In accordance with 42 CFR 438.604(a)(3), 42 CFR 438.606, and 42 CFR 438.8, the Contractor is required to submit data on the basis of which the State determines the compliance with MLR requirements. In addition, the State provides the following clarifications:

- The MLR calculation shall be performed separately for each MLR reporting year per 42 CFR 438.8(a).
- The MLR calculation shall be performed separately for each program. The MLR for the HIP program shall be calculated separately from other managed care programs.
- For purposes of MLR reporting, the Contractor should aggregate data for all Medicaid eligibility groups covered under the Contract with the State.
- Timing:
    - For each MLR reporting year, the Contractor must submit the MLR report within 12 months of the end of the reporting year, reflecting nine months of claims run-out. IBNR should not be included in the MLR calculation as the State will apply appropriate completion factors to the reported claims.
    - The Contractor must require any third party vendor providing claims adjudication services to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner.
- The MLR report submitted by the Contractor for each reporting year must include the following elements, as defined in 42 CFR 438.8:
    - Number of member months in the reporting year
    - Premium revenue
    - Taxes
    - Licensing fees
    - Regulatory fees
    - Incurred claims
    - Expenditures for Quality Improvement activities

- Expenditures for Fraud prevention activities as defined in 42 CFR 438.8(e)(4)
- Non-claims costs
- Any credibility adjustment applied
- Remittance owed to the State, if any
- A comparison of the information reported on the MLR with the audited financial report
- A description of the aggregation method used to calculate total incurred claims
- A description of the methodology used to allocate expenses
- An attestation as to the accuracy of the calculation, in accordance with MLR standards.

- Incurred Claims:
  - Incurred claims submitted for each reporting year should include total incurred claims for the reporting year, and should not include claims incurred in prior years, regardless of when they were paid.
  - Incurred claims reported in the MLR should relate only to members who were enrolled with the Contractor on the dates of service, based on data and information available on the reporting date. (Claims for members who were retroactively disenrolled should be recouped from providers and excluded from MLR reporting).
  - Under sub-capitated or sub-contracted arrangements, the Contractor may only include amounts actually paid to providers for covered services and supplies as incurred claims. The non-benefit portion of sub-capitated and sub-contracted payments should be excluded from incurred claims. The Contractor should ensure all subcontracts provide for sufficient transparency to allow for this required reporting.
- Expenditures may not be duplicated across expense categories or contracts:
  - Each expenditure must be reported under only one expense category, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be

pro-rated between types of expenses.

- Expenditures that benefit multiple contracts or populations must be reported on a pro rata basis.
- Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
- Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities.
- Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

- Credibility adjustment:
  - Contractors may not add a credibility adjustment to the calculated MLR if the reporting year experience under the Contract is fully credible.
  - Contractors may add a credibility adjustment to the calculated MLR if the MLR reporting year experience under the Contract is partially credible.
  - The credibility adjustment should be calculated using credibility factors published by CMS, as specified in 42 CR 438.8(h)(4).
  - The credibility adjustment should be added to the reported MLR calculation before calculating the remittance, if any.
  - If the Contractor's experience under the contract is non-credible, it is presumed to meet or exceed the MLR calculation standards.

The Contractor shall maintain, at minimum, a MLR of eighty-seven percent (87%) for the HIP line of business per 42 CFR 438.8(c).

The Contractor is required to submit MLR reporting as described in the MCE Reporting Manual and the MCE Policies and Procedures Manual for HIP.

In any instance where the State makes a retroactive change to the capitation payments for the MLR reporting year where the MLR report has already been submitted, the Contractor must re-calculate the MLR for all reporting years affected by the change and submit a new MLR report meeting the applicable requirements per 42 CFR 438.8(m) and 42 CFR 438.8(k).

FSSA shall recoup excess capitation paid to the Contractor in the event that the Contractor's MLR is less than eighty-seven percent (87%) for the HIP line of

business.

2.5.7 Reserved

2.6 Subcontracts

The term "subcontract(s)" includes contractual agreements between the Contractor and health care providers or other ancillary medical providers.

Per 42 CFR 438.2, a provider is defined as any individual, organization, or institution (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, ambulatory surgical centers, outpatient clinics etc.) that provides medical services to beneficiaries covered under this Contract.

Additionally, the term "subcontract(s)" includes contracts between the Contractor and another prepaid health plan, physician-hospital organization, any entity that performs delegated activities related to the Contract and any administrative entities not involved in the actual delivery of medical care.

The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with the State, notwithstanding any relationship(s) with any subcontractor per 42 CFR 438.230(b)(1) and 42 CFR 438.3(k).

As specified in Section 13.0, any entity contracted to administer or host the POWER Accounts for HIP members or to provide any point-of-sale infrastructure will be considered a subcontractor.

FSSA must review and approve all subcontractors and any change in subcontractors or material change to subcontracting arrangements as outlined in Section 2.9 to subcontracting arrangements. FSSA may waive its right to review subcontracts and material changes to subcontracts. Such waiver shall not constitute a waiver of any subcontract requirement. Subcontracts with entities that are located outside of or will perform work outside of the United States and Territories of the United States are prohibited. The State encourages the Contractor to subcontract with entities that are located in the State of Indiana.

According to IC 12-15-30-5, subcontracts, including provider agreements, cannot extend beyond the term of the Contract between the Contractor and the State but may automatically renew consistent if the Contract is re-awarded by subsequent procurement. A reference to this provision and its requirements shall be included in all provider agreements and subcontracts.

The Contractor is responsible for monitoring and the performance of any obligations that may result from the Contract. Subcontractor agreements do not terminate the legal responsibility of the Contractor to the State to ensure that all activities under the Contract are carried out. The Contractor shall oversee subcontractor activities and submit an annual report on its subcontractors' compliance, corrective actions, and outcomes of the Contractor's monitoring activities. The Contractor shall provide to FSSA the findings of all subcontractor performance monitoring and reviews upon request and shall notify FSSA any time a subcontractor is placed on corrective action. The Contractor will be held accountable for any functions and responsibilities that it delegates.

The Contractor shall provide that all subcontracts with other prepaid health plans, physician

hospital-organizations, any other entity that performs delegated activities related to the Contract and any administrative entities not involved in the actual delivery of medical care, indemnify and hold harmless the State of Indiana, its officers and employees from all claims and suits, including court costs, attorney's fees and other expenses, brought because of injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of the Contractor and/or the subcontractors. This indemnification requirement does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

The subcontracts shall further provide that the State shall not provide such indemnification to the subcontractor.

Contractors that subcontract with prepaid health plans, physician-hospital organizations or another entity that accepts financial risk for services the Contractor does not directly provide shall monitor the financial stability of subcontractor(s) whose payments are equal to or greater than five percent (5%) of premium/revenue. The Contractor shall obtain the following information from the subcontractor at least quarterly and use it to monitor the subcontractor's performance:

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance
- IBNR estimates

At least annually, the Contractor shall obtain the following additional information from the subcontractor and use this information to monitor the subcontractor's performance: audited financial statements including statement of revenues and expenses, balance sheet, cash flows and changes in equity/fund balance and an actuarial opinion of the IBNR estimates. The Contractor shall make these documents available to FSSA upon request and FSSA reserves the right to review these documents during Contractor site visits.

The Contractor shall comply with 42 CFR 438.230, 42 CFR 434.6, and the following subcontracting requirements:

- The Contractor shall obtain the explicit approval of FSSA before subcontracting any portion of the Contract's requirements. Subcontractors may include, but are not limited to a transportation broker, behavioral health organizations (BHOs) and Physician Hospital Organizations (PHOs). The Contractor shall give FSSA a written request and submit a draft contract or model provider agreement at least sixty (60) calendar days prior to the use of a subcontractor. If the Contractor makes subsequent changes to the duties included in the subcontractor contract, it shall notify FSSA sixty (60) calendar days prior to the revised contract effective date and submit the amendment for review and approval. FSSA has sixty (60) days to complete a review and provide an approval or denial on the use of the subcontractor to the Contractor. FSSA shall approve changes in vendors for any previously approved subcontracts.

- The Contractor shall obtain the explicit approval of FSSA for all direct vendors and subcontractors performing services outlined in this Contract. FSSA must approve all revisions to the subcontracts as well. Only direct subcontractors and vendors require approval by the State (i.e. subcontractors of subcontractors do not require separate State approval).

- The Contractor shall obtain approval from the State for all provider contract

templates prior to use. This includes contract templates used by subcontractors.

- The Contractor shall obtain approval from the State for any subcontractor(s) included in a proposed enhanced benefit.

- The Contractor shall not subcontract with the External Quality Review (EQR) or Enrollment Broker contractors.

- The Contractor must seek approval from the State for utilizing vendors for member outreach or to provide direct medical or behavioral care to members. The Contractor is required to provide a report sixty (60) days after the end of each calendar year listing all such agreements. The report should include method of identifying members for the vendor, services provided, number of members for which each contracted vendor provided services, and standard demographics for the members who received the services.

- The Contractor may not advertise or announce the new subcontractor relationship prior to FSSA's approval of the subcontract. For subcontractors which result in a material change triggering member or provider notice, the sixty (60) day FSSA review period for the subcontract, thirty (30) day period for document review, and thirty (30) or forty-five (45) day notice requirement may not run concurrently.

- The Contractor shall evaluate prospective subcontractors' abilities to perform delegated activities prior to contracting with the subcontractor to perform services associated with the HIP program.

- The Contractor shall have a written agreement in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate per 42 CFR 438.230(c)(1)(iii). The written agreement shall be in compliance with all the State of Indiana statutes, and will be subject to the provisions thereof. The subcontract cannot extend beyond the term of the State's Contract with the Contractor.

- The Contractor shall collect performance and financial data from its subcontractors and monitor delegated performance on an ongoing basis and conduct formal, periodic and random reviews, as directed by FSSA. The Contractor shall incorporate all subcontractors' data into the Contractor's performance and financial data for a comprehensive evaluation of the Contractor's performance compliance and identify areas for its subcontractors' improvement when appropriate. The Contractor shall take corrective action if deficiencies are identified during the review.

- All subcontractors shall fulfill all state and federal requirements, including Medicaid laws, regulations, applicable subregulatory guidance and contract provisions, appropriate to the services or activities delegated under the subcontract. In addition, all subcontractors shall fulfill the requirements of the Contract (and any relevant amendments) that are appropriate to any service or activity delegated under the subcontract.

- The Contractor shall submit a plan to the state on how the subcontractor will be monitored for debarred employees.

- For the purposes of an audit, evaluation, or inspection by the State, CMS, the Department of Health and Human Services (DHHS) Inspector General, the

Comptroller General or their designees, the subcontractor shall make available for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, its premises, physical facilities, equipment, books, records contracts, computer, or other electronic systems relating to its Medicaid enrollees per 42 CFR 438.230(c)(3)(iii) and 42 CFR 438.3(k). This contract term shall specify that if the State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the above State and Federal agencies may inspect, evaluate, and audit the subcontractor at any time.

- The Contractor shall comply with all subcontract requirements specified in 42 CFR 438.230, which contains federal subcontracting requirements. All subcontracts, provider contracts, agreements or other arrangements by which the Contractor intends to deliver services required under the Contract, whether or not characterized as a subcontract under the Contract, are subject to review and approval by FSSA and shall be sufficient to assure the fulfillment of the requirements of 42 CFR 434.6, which addresses general requirements for all Medicaid contracts and subcontracts. FSSA may waive its right to review subcontracts, provider contracts, agreements or other arrangements. Such waiver shall not constitute a waiver of any subcontract requirement.

- The subcontract shall specify the activities and obligations, and related reporting responsibilities per 42 CFR 438.230(c)(1)(i)-(ii) and 42 CFR 438.3(k).

The Contractor shall have policies and procedures addressing auditing and monitoring subcontractors' data, data submissions and performance. The Contractor shall integrate subcontractors' financial and performance data (as appropriate) into the Contractor's information system to accurately and completely report Contractor performance and confirm contract compliance.

FSSA reserves the right to audit the Contractor's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. FSSA may require corrective actions and will assess liquidated damages, as specified in Exhibit 2.B, for non-compliance with reporting requirements and performance standards.

The Contractor is prohibited from subcontracting with providers who have been excluded from the federal government or by the Indiana Health Coverage Program (IHCP) for fraud or abuse. The Contractor shall be responsible for checking the lists of providers currently excluded by the State and the federal government every thirty (30) calendar days. The federal list is available at: http://exclusions.oig.hhs.gov. All network providers must be IHCP enrolled providers. The Contractor shall ensure when the IHCP disenrolls a provider, the Contractor also terminates the provider agreement for the Healthy Indiana Plan program.

If the Contractor uses subcontractors to provide direct services to members, such as care coordination and/or behavioral health services, the subcontractors shall meet the same requirements as the Contractor, and the Contractor shall demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The Contractor shall require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.

While the Contractor may choose to subcontract claims processing functions, or portions of those functions, with a state-approved subcontractor, the Contractor shall demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral providers, and will not result in confusion to the provider community about where to

submit claims for payments. For example, the Contractor may elect to establish one post office box address for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, it is the Contractor's responsibility to ensure that the subcontracting organizations forward claims to the appropriate processing entity. Use of a method such as this will not lengthen the timeliness standards discussed in Section 8.5. In this example, the definition of "date of receipt" is the date of the claim's receipt at the post office box.

2.7 Confidentiality of Member Medical Records and Other Information

The Contractor shall ensure that member medical records, as well as any other health and enrollment information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (see 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information, 42 CFR 438.208(b)(6), and 42 CFR 438.224). The Contractor shall also comply with all other applicable state and federal privacy and confidentiality requirements.

2.8 Internet Quorum (IQ) Inquiries

The Contractor shall respond to IQ inquiries within the timeframe set forth by FSSA. When forwarding an IQ inquiry to the Contractor for a response, FSSA shall designate that the inquiry is an IQ inquiry and will identify when the Contractor's response is due. IQ inquiries typically include member, provider and other constituent concerns and require a prompt response.

Failure by the Contractor to provide a timely and satisfactory response to IQ inquiries will subject Contractor to the liquidated damages set forth in Exhibit 2.B.

2.9 Material Change to Operations

A material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, the Contractor's membership or provider network.

Prior to implementing a material change in operation, the Contractor shall submit a request to FSSA for review and approval at least thirty (30) calendar days in advance of the effective date of the change. The request must contain, at minimum, information regarding the nature of the change, the rationale for the change, and the proposed effective date. All material changes must be communicated to members or providers at least thirty (30) days prior to the effective date of the change.

2.10 Future Program Guidance

The State shall make its best efforts to publish a HIP MCE Policies and Procedures Manual on or before the Contract award date and no later than the Contract start date. In addition to complying with the HIP MCE Policies and Procedures Manual, the Contractor shall operate in compliance with future program manuals, guidance and policies and procedures, as well as any amendments thereto. Future modifications that have a significant impact on the Contractor's responsibilities, as set forth in this Scope of Work, will be made through the Contract amendment process.

2.11 Conflict of Interest

The Contractor shall ensure compliance with applicable laws and conflict of interest

safeguards in accordance with 42 CFR 438.3(f).

2.12 Capitation Related to a Vacated Program

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 not implement that part after the effective date of the loss of program authority. The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor received capitation payments that included costs specific to a program or activity no longer authorized by law prior to the effective date of the loss of authority for work that would be performed after that effective date, the State must adjust those capitation payments to ensure that previous reimbursement of costs specific to the program or activity no longer authorized is returned to the State and that costs specific to the program or activity no longer authorized are no longer paid by the State after the effective date of the loss of program authority. Capitation payments received prior to the effective date of loss of program authority that included costs for work specific to the program or activity that is no longer authorized, but that was performed prior to that effective date, may be retained by the Contractor and need not be returned to the State.

2.13 Maintenance of Records

The Contractor shall adhere to the FSSA Records Retention and Disposition Schedule included in the Bidders' Library, including any and all updates to the FSSA Records Retention and Disposition Schedule.

The Contractor and the Contractor's subcontractors shall retain, as applicable enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period of no less than ten (10) years per 42 CFR 438.3(u).

2.14 Maintenance of Written Policies and Procedures

The Contractor shall develop and maintain written policies and procedures for each functional area in compliance with the Code of Federal Regulations, Indiana Code, Indiana Administrative Code, FSSA Policy and Procedure Manuals and the Contract. Written guidelines shall be maintained for developing, reviewing and approving all policies and procedures. The Contractor shall review all policies and procedures at least annually to ensure they reflect current practice and shall be updated as necessary. Reviewed policies shall be signed and dated. All medical and quality management policies shall be reviewed and approved by the Contractor's Medical Director. FSSA has the right to review all Contractor policies and procedures. Should the FSSA determine a Contractor policy requires revision, the Contractor shall work with the FSSA to revise within the timeframes specified by the State. If the FSSA determines the Contractor lacks a policy or process required to fulfill the terms of the Contract, the Contractor must adopt a policy or procedure as directed by FSSA.

2.15 Participation in Readiness Review

The Contractor shall undergo and must pass a two (2)-phase readiness review process and be ready to assume responsibility for contracted services upon the Contract effective date as described in further detail in the Readiness Review requirements and documentation. The Contractor shall maintain a detailed implementation plan, to be approved by FSSA,

which identifies the elements for implementing the proposed services which include, but are not limited to, the Contractor's tasks, staff responsibilities, timelines and processes that will be used to ensure contracted services begin upon the Contract effective date. In addition to submitting the implementation plan with the proposal, the Contractor may be required to submit a revised implementation plan for review as part of the Readiness Review.

2.16 Dissemination of Information

Upon request of the State, the Contractor shall distribute information prepared by FSSA, its designee, or the Federal Government to its members.

2.17 FSSA Ongoing Monitoring

The FSSA shall conduct ongoing monitoring of the Contractor to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of the FSSA and may include, but is not limited to, both scheduled and unannounced onsite visits, review of policies and procedures and performance reporting. Reporting requirements are detailed further in Section 9.0 and the Reporting Manual to be developed by the State.

The reviews will identify and make recommendations for areas of improvement, monitor the Contractor's progress towards implementing mandated programs or operational enhancements, and provide the Contractor with technical assistance when necessary. In preparation for planned onsite reviews, the Contractor shall cooperate with FSSA by forwarding in advance policies, procedures, job descriptions, contracts, records, logs and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities.

3.0 Covered Benefits and Services

The Contractor shall provide to its HIP members, at a minimum, all benefits and services deemed "medically reasonable and necessary" and covered under the Contract with the State. Medically necessary means services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition, are provided for the diagnosis, direct care, and treatment of the member's medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the member or the member's doctor (see also: 42 CFR § 438.210(a)(5)).

Per 45 CFR § 156.115(a)(5), habilitative services and devices include health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples may include therapy for a child who is not walking or talking at the expected age. These services may also include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitative services and devices include health care services and devices to help a member recover from an illness or injury. These services may be given by nurses and physical, occupational, and speech therapists. Examples may include working with a physical therapist to help a member walk and with an occupational therapist to help a member get dressed.

In accordance with 42 CFR 438.210(a)(2)-(3), the Contractor shall deliver covered services sufficient in amount, duration or scope to reasonably expect that provision of such services would achieve the purpose of the furnished services. Per 42 CFR 438.210(a)(2), the Contractor must furnish covered services in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under Fee For Service (FFS) Medicaid. Costs

for these services are the basis of the Contractor's capitation rate and are, therefore, the responsibility of the Contractor. Coverage of services in amount, duration or scope may not be arbitrarily denied or reduced solely because of diagnosis, type of illness, or condition of the beneficiary per 42 CFR 438.210(a)(3)(ii). Coverage is subject to certain limitations in accordance with 42 CFR 438.210(a)(4), which specifies when Contractors may place appropriate limits on services, regarding:

- Criteria applied under the State Plan and medical necessity determinations.
- Utilization control, provided the services furnished are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished; the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20.

Per 42 CFR § 400.203, State Plan refers to the comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the Social Security Act, to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

The Contractor must cover, at minimum, all benefits and services deemed medically necessary and reasonable and covered under the HIP program in accordance with the terms of the Contract. A covered service is medically necessary if, in a manner consistent with accepted standards of medical practice, it is reasonably expected to:

- Not be more restrictive than the State Fee for Service Medicaid program, including Quantitative and Non- Quantitative Treatment Limits, as indicated in State statutes and regulations, the Contractor's and other State policies and procedures per 42 CFR 438.210(a)(5)(i).
- Address the prevention, diagnosis, and treatment of an enrollee's disease, onset of an illness, injury, condition, primary disability or secondary disability, and/or disorder that results in health impairments and/or disability per 42 CFR 438.210(a)(5)(ii)(A).
- Cure, correct, reduce, or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury or disability.
- Reduce or ameliorate the pain or suffering caused by an illness, injury, condition, or disability.
- Cover services related to the ability for an enrollee to achieve age-appropriate growth and development per 42 CFR 438.210(a)(5)(ii)(B).
- Cover services related to the ability for an enrollee to attain, maintain, or regain functional capacity per 42 CFR 438.210(a)(5)(ii)(C).

The Contractor may cover services necessary for compliance with requirements for parity in mental health and substance use disorder benefits in 42 CFR Part 438, subpart K, identified with the analysis of parity compliance conducted by the State or the Contractor per 42 CFR 438.3(e)(1)(ii).

3.1 Covered Benefits and Services

HIP covered services include all services, including coverage criteria, limitations and

procedures, identified in the HIP alternative benefit plans (ABP) and the Indiana State Plan (only applicable for HIP State Plan members) approved by CMS and meeting the requirements as set forth in Section 1937 of the Social Security Act. In the event the requirements of any HIP alternative benefit plan as approved by CMS conflicts with any of the terms of this Contract, the requirements of the alternative benefit plan shall prevail. Exhibit 3.B of the Contract provides a general summary description of the different HIP benefit packages and the services and benefits that are available under each.

HIP covers the ten essential health benefits, as detailed by the alternative benefit plans: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) maternity and newborn care; (v) mental health and substance use disorder services, including behavioral health treatment; (iv) prescription drugs; (vii) rehabilitative and habilitative services and devices; (viii) laboratory services; (ix) preventive and wellness services and chronic disease management; and (x) pediatric services. Except as otherwise stated in this Scope of Work, HIP covered services are subject to a $2,500 annual deductible, to be paid with POWER Account funds.

Where the State has established a minimum fee schedule, the Contractor shall reimburse HIP providers for covered services at a rate not less than the minimum fee schedule. This is a State-directed minimum fee schedule payment as described in 42 CFR 438.6(c)(1(iii)(A). However, in instances where the Contractor pays for a service provided to a HIP Basic member, the Contractor shall exclude the amount of the required HIP Basic copayment from the rates paid to the provider.

The Contractor shall not pay for organ transplants unless the Contractor follows the written standards included in the State Plan that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to members. For additional information, please see the following:

- https://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_3/3.1e.pdfn
- https://provider.indianamedicaid.com/ihcp/StatePlan/Section_3/3.1.f.g.h.pdf

3.2 Self-referral Services

In accordance with state and federal requirements, HIP program include some benefits and services that are available to members on a self-referral basis. These self-referral services shall not require a referral from the member's PMP or authorization from the Contractor.

The Contractor shall include self-referral providers in its contracted network. Note that network is defined as a list of the doctors, other health care providers, and hospitals that the Contractor contracts with to provide medical care to its members. These providers are called "network providers" or "in-network providers." A provider that isn't contracted with the Contractor is called an "out-of-network provider." The Contractor and its PMPs may direct members to seek the services of the self-referral providers contracted in the Contractor's network. However, with the exception of behavioral health and routine dental services, the Contractor cannot require that the members receive such services from network providers.

With the exception of family planning services and emergency services, when HIP members choose to receive self-referral services from IHCP-enrolled self-referral providers, they shall go to an in-network provider or receive prior authorization to go to an out- of-network provider. The Contractor is responsible for payment for self-referral services up to the applicable benefit limits and at a rate not less than the minimum fee schedule

established by the State.

Members may not self-refer to a provider who is not enrolled in IHCP. The following services are considered self-referral services. The Indiana Administrative Code 405 IAC 5 and 405 IAC 10-7 provides further detail regarding these benefits.

- Chiropractic services may be provided by a licensed chiropractor, enrolled as an Indiana Medicaid provider, when rendered within the scope of the practice of chiropractic as defined in IC 25-10-1-1 and 846 IAC 1-2-1. Chiropractic manipulation services may only be provided to members receiving services through HIP State Plan, HIP Plus, or while receiving the additional HIP pregnancy-only benefits. Chiropractors may provide other therapy services in their scope of practice to all HIP members.

- Eye care services, except surgical services may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) or IC 25-24 (optometrist) who has entered into a provider agreement under IC 12-15-11. Eye care services may be provided to members receiving services through HIP State Plan, HIP Plus, or while receiving the additional HIP pregnancy-only benefits.

- Routine dental services may be provided by any in-network licensed dental provider who has entered into a provider agreement under IC 12-15-11. Dental services may be provided to members receiving services through HIP State Plan, HIP Plus, or while receiving the additional HIP pregnancy-only benefits.

- Podiatric services (HIP State Plan only) may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) or IC 25-29 (doctor of podiatric medicine) who has entered into a provider agreement under IC 12-15-11.

- Psychiatric services may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) who has entered into a provider agreement under IC 12-15-11.

- Family planning services under federal regulation 42 CFR 431.51(b)(2) and section 1902(a)(23) of the Social Security Act requires a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Contractors may place appropriate limits on the service for utilization control, provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used per 42 CFR 438.210(a)(4)(ii)(C). Family planning services also include sexually transmitted disease testing. Members may self-refer to any IHCP provider qualified to provide the family planning service(s), including providers that are not in the Contractor's network. Members may not be restricted in choice of a family planning service provider, so long as the provider is an IHCP provider. The IHCP Provider Manual provides a complete and current list of family planning services.

  Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Abortions are only covered if the pregnancy is the result of an act of rape or incest or a case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would as certified by a physician, place the woman in danger of death unless

an abortion is performed and in compliance with 42 CFR 441.202.

- Emergency services are covered without the need for prior authorization or the existence of a contract with the emergency care provider. Emergency services shall be available twenty-four (24)-hours-a-day, seven (7)-days-a-week subject to the "prudent layperson" standard of an emergency medical condition, as defined in 42 CFR 438.114(b), 42 CFR 438.114(c), and section 1852(d)(2) of the Act, which relates to emergency and post-stabilization services, and IC 12-15-12. See Section 3.6 for more information.

- Urgent care services are covered for HIP members on a self-referral basis. See Section 5.2.12 for specific urgent care network requirements.

- Immunizations are self-referral to any IHCP-enrolled provider. Immunizations are covered regardless of where they are received.

- Diabetes self-management services are self-referral if rendered by a self-referral provider. See Section 3.10 for more detail.

- Behavioral health services are self-referral if rendered by an in-network provider. Members may self-refer, within the Contractor's network, for behavioral health services not provided by a psychiatrist, including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers.

3.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

EPSDT is a federally-mandated preventive health care program designed to improve the overall health of Medicaid-eligible infants, children and adolescents from birth to twenty-one (21) years old. EPSDT includes all IHCP- covered preventive, diagnostic and treatment services, as well as other prior-authorized treatment services that the screening provider determines to be medically necessary. In addition, EPSDT services include the provision of medically necessary services to members less than twenty-one (21) years old in institutions of mental disease (IMDs). All requests for EPSDT services not otherwise covered under the State Plan must be reviewed for medical necessity for eligible members.

The primary goal of EPSDT is to ensure that children enrolled in IHCP receive age-appropriate comprehensive, preventive services. Early detection and treatment can reduce the risk of more costly treatment or hospitalization resulting from delayed treatment. Per 40 CFR § 159.153, hospitalization means admission for treatment to a hospital, clinic, or other health care facility. Treatment as an out-patient is not considered to be hospitalization. See 405 IAC 5-15-3 and the IHCP EPSDT Provider Manual for details regarding components and further information.

The Contractor shall educate pregnant women and work with prenatal clinics and other providers to educate pregnant women about the importance of EPSDT screenings and encourage them to schedule preventive visits for their infants.

HIP members 19 years of age through the first month of their 21st birthday may be covered by EPSDT.

3.4 Drug Coverage

Prescription drugs, certain over-the-counter drugs, pharmacy supplements, and other specified products are benefits under the HIP program to be covered by the Contractor. Per 21 § CFR 203.3(y), prescription drug means any drug (including any biological product, except for blood and blood components intended for transfusion or biological products that are also medical devices) required by Federal law (including Federal regulation) to be dispensed only by a prescription, including finished dosage forms and bulk drug substances subject to section 503(b) of the Social Security Act.

The Contractor agrees to abide by 42 CFR 438.3(s), the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) and P.L. 115-271, "SUPPORT" Act. The Contractor shall follow the statewide unified preferred drug list (SUPDL) for the pharmacy benefit. The SUPDL will consist of the fee-for-service (FFS) PDL. Adoption of the SUPDL shall include alignment of prior authorization (PA), forms, and step edit and utilization edit criteria for drugs and drug classes that are part of the SUPDL. The Contractor will discontinue and not seek commercial discounts and commercial rebate agreements with pharmaceutical manufacturers for IHCP member pharmacy benefits.

The Contractor may only set a Maximum Allowable Cost (MAC) rate on a multiple source drug available from at least two manufacturers. The MAC rate may not be applied when the brand product is preferred over available generics on the SUPDL.

The Contractor shall assure proper and complete PBM agent training.

The Contractor shall always ensure that, at all times during the term of this contract, its pharmacy benefit fully complies with applicable provisions of law including IC 12-15-35 and IC 12-15-35.5.

The Contractor shall develop an escalation process for specified unique review processes and requests submitted by State or federal legislators, the Governor, the Secretary, news media and/or of a controversial nature.

The Contractor shall assure that all claims (including emergency claims) from a non-IHCP pharmacy will reject. In addition, all claims (except emergency claims) from a non-IHCP prescribing provider will reject.

If the Contractor enters into a contract or agreement with a Pharmacy Benefit Manager (PBM) for the provision and administration of pharmacy services, the contract or agreement shall be developed as a pass-through pricing model as defined below:

All monies related to services provided for the Contractor are passed through to the Contractor, including but not limited to dispensing fees and ingredient costs paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, rebates (including manufacturer fees and administration fees for rebating), inflationary payments, and supplemental or commercial rebates;

All payment streams, including any financial benefits such as rebates, discounts, credits, clawbacks, fees, grants, reimbursements, or other payments that the PBM receives related to services provided for the Contractor are fully disclosed to the Contractor, and provided to the State upon request, and;

The PBM is paid an administrative fee which covers the cost of providing the PBM services as described in the PBM contract or agreement as well as margin.

The payment model for the PBM's administrative fee shall be made available to the State. If concerns are identified, the State reserves the right to request any changes be made to the payment model.

A contract holder may one time in a calendar year and not earlier than six months following a previously requested audit, request and audit of compliance with the contract. If requested by the contract holder, the audit shall include all requirements outlined in IC 27-1-24.5-25. However, in instances where the contract holder or the State Medicaid Agency receives a complaint of Medicaid Fraud or abuse from any source or identifies any questionable practices, a preliminary investigation, which may include an audit, will be conducted regardless of any prior audit pursuant to 42 CFR 455.14.

3.4.1 Drug Rebates

The Contractor shall take all steps necessary to participate in, and support FSSA's participation in, federal and supplemental drug rebate programs by terminating, and not entering into, rebate agreements with its Pharmacy Benefit Managers (PBMs) or with manufacturers for any drugs.

The Contractor shall ensure compliance with the requirements under Section 1927 of the Social Security Act. In accordance with the Affordable Care Act, manufacturers that participate in the Medicaid drug rebate program are required to pay rebates for drugs dispensed to individuals enrolled with a Medicaid Managed Care Entity. To facilitate collection of these rebates, FSSA shall include utilization data of HIP contractors when requesting quarterly drug rebates from manufacturers as well as in quarterly utilization reports to the Centers for Medicare and Medicaid Services (CMS). The Contractor shall provide reports to the State to support rebate collection per 42 CFR 438.3(s)(2) and section 1927(b)(1)(A) of the Social Security Act. This reporting shall include physician-administered drugs. The State intends to use and share the Contractor paid amount information on the State's pharmacy claims extracts for rebate purposes.

The Contractor shall provide this reporting to the State in the manner and timeframe prescribed by FSSA, including, but not limited to, through the submission of complete and accurate pharmacy encounter data and a rebate file to the State or its designee. Per 42 CFR 438.3(s)(2) and section 1927(b)(1)(A) of the Social Security Act, the report will include information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed to Contractor members and such other data that the Secretary of CMS determines necessary for the State to access rebates. This reporting shall include physician-administered drugs. For more information on reporting, please refer to Section 9, as well as the HIP MCE Reporting Manual. An example of a rebate file is provided in the Bidders' Library; this file layout is provided as an example only and is subject to change. Throughout the course of the Contract, FSSA may update the file layout to support rebate collection. FSSA shall make its best effort to provide the Contractor sixty (60) days advanced notice of the change and the Contractor shall be required to comply with the change in the timeframe designated by the State. The Contractor shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of paid amounts. Failure to comply with the drug rebate reporting requirements established by FSSA will subject the Contractor to the remedies outlined in Contract Exhibit 2.B Contract Compliance and Pay for Outcomes. Requirements for pharmacy encounter claims are outlined in Section 8.6. Additionally, the Contractor shall assist FSSA or the State's PBM contractor in resolving drug rebate disputes with a manufacturer, at Contractor's expense.

As maximization of drug rebates is heavily dependent on cooperation by the Contractor with the State or the State's designated rebate vendor, the Contractor must respond to all inquiries from the State or the vendor pertaining to all drug rebate matters in a timely fashion. The Contractor must acknowledge receipt of such inquiries in writing (e.g., by e-mail) within two (2) business days of receipt, and in that acknowledgement provide a best estimate of when a final response will be provided.

3.4.2 SUPDL and Formulary Requirements

For purposes of this section, the "formulary" is defined as the SUPDL and "non-formulary" is defined as covered outpatient drugs not included in the SUPDL.

The Contractor shall maintain formulary (i.e., SUPDL) and covered non-formulary (i.e., non-SUPDL) drug lists for the Contractor's Healthy Indiana Plan packages. The Contractor must use the SUPDL as its formulary and may not develop and use its own PDL for any therapeutic categories that are part of the SUPDL. The Contractor will be provided opportunities to offer feedback on the SUPDL to the State. The State shall provide the Contractor with fifteen (15) calendar days' notice of any change to the SUPDL, except those changes resulting from a drug shortage, recall or discontinuation, and the Contractor shall have an additional fifteen (15) calendar days to implement the change, including any system change. A drug that is on the SUPDL must have the same criteria and forms as the FFS PDL even if it is reimbursed as a medical claim.

The Contractor shall submit any changes to the contents of the approved non-formulary drug list and any changes to prior authorization or medical necessity criteria applied to the non-formulary drug list to OMPP at least 60 days prior to the intended implementation date. OMPP may disapprove or modify the proposed changes within 30 days of receipt. If no response is received from OMPP within 30 days, the Contractor may implement the proposed changes.

The formulary and non-formulary covered drug lists shall support the coverage and non-coverage requirements for legend and non-legend drugs by Indiana Medicaid. More information can be found in 405 IAC 5-24-3, 405 IAC 5-24-4, 405 IAC 5-24-5, and 405 IAC 13-9.

In accordance with CMS-2390-F and 42 CFR 438.210, the Contractor shall demonstrate prescription drug coverage consistent with the amount, duration, and scope of the fee-for-service program. Per 42 CFR § 423.100, prescription drug coverage means coverage of Part D drugs that is either standard prescription drug coverage or basic alternative coverage.

The Contractor shall follow the SUPDL prior authorization criteria for SUPDL drug classes. Per 42 CFR § 419.81, preauthorization (or prior authorization) means the process through which a request for provisional affirmation of coverage is submitted to CMS or its contractors for review before the service is provided to the beneficiary and before the claim is submitted for processing.

Per 42 CFR 438.10(i)(1)-(2), the Contractor shall make available in electronic or paper form, the covered drug list(s) of medications including the reference brand and generic names of each drug as well as what tier each drug is on.

The Contractor shall utilize a Pharmacy and Therapeutics Committee which shall meet regularly to make recommendations for changes to non-formulary covered outpatient drugs. The Contractor shall maintain an Over-the-Counter (OTC) Drug

Formulary and Contraception Formularies and a Pharmacy Supplements Formulary which contains, at a minimum, the same items included in the FFS OTC Drug Formulary and Contraception Formularies and the Pharmacy Supplements Formulary and as updated by the DUR Board. Any additions to the Contractor OTC Drug Formulary are required to only be from participating rebating labelers.

The formulary (i.e., SUPDL) and non-formulary (i.e., non-SUPDL) covered drug lists shall be made readily available to providers in the Contractor's network and to members by linking to the Pharmacy Services page on https://www.in.gov/medicaid/. The formulary and non-formulary covered drug lists shall be updated and posted on or before the intended implementation date to reflect all changes in the status of a drug or addition of new drugs. The Contractor shall also support e-Prescribing technologies to communicate the formulary SUPDL and non-formulary drug lists and covered drugs to prescribers through electronic medical records (EMRs) and e-Prescribing applications. Refer to Section 3.4.5 for additional requirements on e-Prescribing. Consistent with the requirements of Section 5.7, the Contractor shall develop provider education and outreach aimed at educating providers about the HIP formulary as well as the utilization of e-Prescribing technologies to ensure appropriate prescribing for members based on the member's benefit plan. The Contractor shall assure that non-drug products approved for use in compounding are not subject to rebating manufacturer requirements.

Also, prescriptions obtained by a HIP member that are not otherwise exempt on the basis outlined in Section 13.0, are subject to the copayment amounts set forth in the same Section. Copayments assessed to the HIP member at the point of sale may not exceed the total cost of the drug.

While the underlying drug formulary for the HIP Plus and the HIP Basic plans will be identical, additional pharmacy services may differ between the plans in order to align the benefits with the overall program goals aimed at encouraging member participation in HIP Plus.

Therefore, the HIP Basic or HIP State Plan Basic pharmacy benefits may have more restrictions than the HIP plus benefit. For example, prescriptions obtained under the HIP Basic or HIP State Plan Basic that are not otherwise exempt on the basis of being preventive, family planning, or maternity, are subject to the copayment amounts set forth in Sections 13.1.1 and 13.1.2. Copayments assessed to the HIP Basic or HIP State Plan Basic member at the point of sale may not exceed the total cost of the drug.

Both HIP Basic and HIP Plus members will have access, upon request, to ninety (90) days' prescription supplies for routine maintenance medications.

3.4.3 DUR Board and MHQAC Reporting Requirements

In accordance with IC 12-15-35-48, the DUR Board shall review the prescription drug programs of the Contractor at least one (1) time per year. This review shall include, but is not limited to, review of the following for non-formulary (i.e., non-SUPDL) covered drug list categories:

- An analysis of the single source drugs requiring prior authorization in comparison to other contractor's prescription drug programs in the HIP program.

- A determination and analysis of the number and the type of drugs subject to a restriction.

- A review of the rationale for the prior authorization of a drug and a restriction on a drug.

The DUR Board review shall include, but is not limited to, review of the following for all categories, including SUPDL drug categories:

- A review of the number of requests a Contractor received for prior authorization, including the number of times prior authorization was approved and disapproved.

- A review of patient and provider satisfaction survey reports and pharmacy-related grievance data for a twelve (12) month period.

The Contractor shall provide OMPP with the information necessary for the DUR Board to conduct this review in the timeframe and format specified by OMPP. OMPP may identify therapeutic drug classes or specific drug products for which the Contractor may be required to bring to the DUR Board for review prior to the implementation of any changes in coverage or utilization management criteria.

The Contractor shall comply with any reporting requests required for submission to the DUR Board and the Mental Health Quality Advisory Committee (MHQAC). Please refer to the MCE Reporting Manual for more information on pharmacy reporting requirements.

All mental health drugs described in IC 12-15-35.5 are considered preferred and included on the SUPDL. The Contractor shall comply with all SUPDL requirements pertaining to mental health drugs.

The Contractor shall provide the DUR Board statistics at the DUR Board's monthly meetings. These statistics may include information on drug utilization or prior authorization reports as requested by the State.

3.4.4 Dispensing and Monitoring Requirements

The Contractor shall administer pharmacy benefits in accordance with all applicable state and federal laws and regulations, and State pharmacy policy. For the SUPDL drug classes that indicate them, the Contractor's quantity limits and age edits must follow the SUPDL unless otherwise reviewed and prior approved by the State. For any drugs which require prior authorization, the Contractor shall provide a response by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization per 42 CFR 438.210(d)(3). Additionally, the Contractor shall provide for the dispensing of at least a seventy-two (72) hour Emergency supply of a covered outpatient prescription drug, as required under 42 U.S.C 1396r-8(d)(5)(B), without prior authorization. The Contractor shall allow for 90-day supply for maintenance drugs (does not apply to specialty drugs).

The Contractor shall implement prior authorization for the SUPDL approved for all plans by the DUR Board. For non-formulary covered drug classes, the Contractor may apply prior authorization requirements, such as general member information, a justification of need for drug related to the medical needs of the member and a planned course of treatment, if applicable, as related to the quantity of drug provided and duration of treatment. The Contractor will be required to have a process in place

to allow drugs that are medically necessary but not included in the formulary or non-formulary covered drug lists to be accessed by members. The Contractor will be required to accept prior authorization requests via telephone, fax, web-based system, or in writing. To conform to 42 CFR 438.3(s) and the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F), any medical necessity criteria applied by the Contractor may not be more stringent than any established FFS criteria for non-formulary covered drug classes. For formulary (SUPDL) drug classes, the Contractor shall follow the SUPDL criteria.

The Contractor shall provide online and real-time rules-based point-of-sale (POS) claims processing for pharmacy benefits. In accordance with 42 CFR Part 456, subpart K and 42 CFR 438.3(s)(4), the Contractor shall operate drug utilization review as described in this section. The Contractor shall maintain prospective drug utilization review edits and apply these edits at the POS. These criteria and edits must be reviewed and approved by the DUR Board prior to implementation. The Contractor shall maintain prospective drug utilization review criteria and edits for covered outpatient drugs that the Contractor limits to medical benefit coverage. All criteria and edits applied to covered outpatient drugs for the pharmacy benefit and/or the medical benefit will be posted online, linked to the https://www.in.gov/medicaid/ website. Additionally, the Contractor shall implement a retrospective drug utilization program to analyze for drugs or specific groups of drugs to document utilization trends and intervene with identified prescriber practice outliers leading to educational interventions which emphasize clinically sound and cost-effective care. The Contractor must also implement a program to identify and report fraud and abuse among providers and members.

Additionally, the Contractor shall implement retrospective drug use review to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits, or associated with specific drugs or groups of drugs.

1. Administration of all criteria, common or independent, shall be performed by the Contractor or its subcontracted PBM. The MCE shall regularly report findings on audits performed and outcomes completed by the PBM on providers

2. The MCE shall regularly report findings on audits performed and outcomes completed by the MCE on its PBM

3. The MCE shall immediately report, to FSSA:

    a. Claims processing outages experienced by the MCE and/or its PBM
    b. The MCE shall provide a root cause analysis of the outage to the Office in a timely manner
    c. Claims processing errors
        i. The MCE shall provide a root cause analysis of the claims processing error to the Office in a timely manner

3.4.5 E-Prescribing

The Contractor shall support e-Prescribing services. Much of the e-Prescribing activity is supported by prescribing providers through web and office-based applications or certified electronic health record (EHR) systems to communicate with

the pharmacies. When EHR systems are used, the Contractor shall supply the EHR systems with information about member eligibility, patient history and drug formulary.

3.4.6 Carve-Out of Select Drugs

Exhibit 3.B of this Contract contains the list of drugs and agents excluded from the Contractor's capitation rate. These are referred to as "carved-out" drugs. The State's fiscal agent pays claims for carved-out drugs on a fee-for-service basis for the Contractor's members. While these drugs are not the financial responsibility of the Contractor, the Contractor shall ensure coordination of all Medicaid covered drugs and implement strategies to prevent duplication and fragmentation of care across the healthcare delivery system.

3.4.7 340B

The Contractor shall comply with 42 USC 256B and the requirements therein. Additionally, the Contractor shall comply with all policies and procedures set forth in IHCP Provider Bulletin BT201413, dated April 1, 2014, and any updates thereto.

The Contractor must have procedures in place to exclude utilization data for drugs subject to discounts under the 340B Drug Pricing Program from the utilization reports submitted to the State per 42 CFR 438.3(s)(3). Specific plans for excluding utilization data should be detailed and agreed upon between the Contractor and the State and may use tools including, but not limited to, modifiers, billing instructions, and processes to correctly identify a 340B patient.
At any given point in time, the State may elect to require the use of 340B-related modifiers on claims. In such an instance, the Contractor shall require its providers to use the selected modifiers on their claims, and the Contractor will be required to deny payment for claims that do not contain necessary modifiers. The State will work with the Contractor in determining a mutually agreeable workplan and timeline for implementation of use of modifiers by the Contractor's providers.

The Contractor shall, on an ongoing basis, monitor claims for provider compliance with federal and state billing requirements pertaining to 340B-sourced drugs. The Contractor shall be fully responsible for ensuring that its providers bill for 340B drugs completely in compliance with federal and state requirements, such as prevention of duplicate discounts. The Contractor must maintain records that are clear and auditable that include billing instructions and methods by which 340B claims are excluded from Medicaid reimbursement. The Contractor shall allow the State access to any data upon its request to records related to 340B purchased drugs, exclusion from Medicaid reimbursement, and utilization reports.

In the event that a duplicate discount claim is pursued, the Contractor is responsible for working with the State's designated rebate vendor and any involved providers to address the claim and resolve any manufacturer dispute or rebate invoice matter. In the event that a duplicate discount, diversion, or other impermissible utilization of drugs obtained through the 340B program derived from Contractor utilization is substantiated through appropriate means, the Contractor will be responsible for repayment of the duplicate discount and any sanction resulting therefrom. The State will not be responsible for payment for duplicate discounts.

3.4.8 Pharmacy Continuity of Care

The Contractor shall provide for ninety (90) days of continuity of care for all pre-existing drug regimens for all new members. This will allow time for the PBM to work with the prescribing provider to negotiate future drug regimens.

3.4.9 SUPPORT Act Compliance

In accordance with the federal Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act and section 1902(a)(85) of the Social Security Act, the Contractor shall implement and maintain the following processes and standards:

1. Safety edits and claims review automated process for the State-approved maximum daily morphine limitation

2. Prospective safety edits on subsequent fills of opioid prescriptions, as specified by the State, which may include edits to address days' supply, early refills, duplicate fills, and quantity limitations for clinical appropriateness

3. Prospective safety edits and claims review automated process for the State-approved maximum daily morphine equivalent on opioid prescriptions

4. Retrospective reviews on opioid prescriptions exceeding above limitation on an ongoing basis

5. Claims review automated process that monitors when a client is concurrently prescribed opioids and benzodiazepines, or is concurrently prescribed opioids and antipsychotics on an ongoing basis

6. Program to monitor and manage the appropriate use of antipsychotic medications by Medicaid children

7. Process that identifies potential fraud or abuse of controlled substances by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies

3.4.10 Diabetes Supplies Coverage

The Contractor shall provide Diabetic Supplies Coverage. The Contractor shall cover diabetic supplies in alignment with FSSA's Preferred Diabetic Supply List (PDSL). The Contractor shall configure its claims payment system to approve the diabetic supplies of FSSA's contracted preferred vendors to supply blood glucose monitors and diabetic test strips for all IHCP enrollees. The Contractor shall ensure that NDCs for diabetic supplies are included on all claims. The Contractor shall require prior authorization for all nonpreferred diabetic supplies.

3.5 Smoking Cessation and Tobacco Dependence Treatment

For HIP State Plan benefits and any member eligible under any HIP category for HIP Maternity benefits (see Section 12.4), the Contractor must cover, at minimum, Smoking Cessation and Tobacco Dependence Treatment as set forth in 405 IAC 5-37. Drug coverage and criteria shall be consistent with the fee-for-service program (refer to 3.4 Drug Coverage), including individual and/or group counseling and all covered outpatient drugs indicated for Smoking Cessation and Tobacco Dependence Treatment. Licensed practitioners within their scope of license under Indiana law may prescribe one or more

modalities of treatment. Practitioners must include individual and/or group counseling in any combination of treatment. The Contractor shall provide each member identified as using tobacco or tobacco related products, information regarding the availability of tobacco cessation services provided through the Indiana Quitline. The Contractor shall create and implement a physician incentive program specific to tobacco dependence counseling. Contractor shall utilize a promotional strategy for tobacco cessation medications approved by FSSA to increase appropriate use of member drug benefits. The Contractor shall comply with policies and procedures set forth the IHCP Provider Bulletin regarding Tobacco Dependence individual and/or group counseling sessions dated November 15, 2022 (BT2022100), and any updates thereto.

For HIP Plus and HIP Basic benefits, the Contractor shall cover the tobacco dependence benefits described in the Alternative Benefit Plan. See Exhibit 3.B of this Contract for more information.

3.6 Emergency Care

The Contractor shall cover emergency services and emergency medical transportation without the need for prior authorization or the existence of a contract with the emergency care provider per 42 CFR 438.114(c)(1)(i).

Per 405 IAC 5-2-9, emergency service is defined as a service provided to a member after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Per 836 IAC 1-1-1, emergency medical transportation means the transportation of emergency patients by ambulance and the administration of basic life support to emergency patients before or during such transportation.

Services for treatment of an emergency medical condition, as defined in 42 CFR 438.114, which relates to emergency and post-stabilization services, and IC 12-15-12 (i.e., subject to the “prudent layperson” standard), shall be available twenty-four (24)-hours-a-day, seven (7)-days-a-week. Per 42 CFR § 438.114, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part.

The Contractor shall cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations under section 1867 and 42 CFR 489.24, which sets special responsibilities for hospitals in emergency cases, provided to a member who presents to an emergency department with an emergency medical condition. The Contractor shall also comply with all applicable emergency services requirements specified in IC 12-15-12. The Contractor shall reimburse out-of-network providers at a rate not less than the minimum fee schedule. The Contractor is required to reimburse for the medical screening examination and facility fee for the screening but is not required to reimburse providers for services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition, unless the Contractor authorized this treatment. The Contractor shall pay the contracted or fee schedule rate for an

observation stay, regardless of whether a related emergency department visit was determined emergent.

In accordance with 42 CFR 438.114, which relates to emergency and post-stabilization services, the Contractor may not limit what constitutes an emergency on the basis of lists of diagnoses or symptoms per 42 CFR 438.114(d)(1)(i). The Contractor may not deny payment for treatment obtained when a member had an emergency medical condition, even if the outcomes, in the absence of immediate medical attention, would not have been those specified in the definition of emergency medical condition, and may not deny payment for treatment obtained when a representative of the Contractor instructs the enrollee to seek emergency services per 42 CFR 438.114(c)(1)(ii). The Contractor may not deny or pay less than the allowed amount for the CPT code on the claim without offering the provider the opportunity for a medical record review. The Contractor shall conduct a prudent layperson review to determine whether an emergency medical condition exists; the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field. A prudent layperson would no longer be qualified after an average of two (2) to three (3) years spent on the job due to the on-the-job medical training/experience and would require replacement.

The Contractor is prohibited from refusing to cover emergency services if the emergency room provider, hospital or fiscal agent does not notify the member's PMP or the Contractor of the member's screening and treatment within ten (10) calendar days of presentation for emergency services per 42 CFR 438.114(d)(1)(ii). The member who has an emergency is not liable for the payment of subsequent screening and treatment that may be needed to diagnose or stabilize the specific condition per 42 CFR 438.114(d)(2). Per 42 CFR 438.114(d)(3), the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. In addition, the attending physician's determination is binding and the Contractor may not challenge the determination.

The Contractor shall comply with policies and procedures set forth the IHCP Provider Bulletin regarding Emergency Room Services Coverage dated January 30, 2020 (BT202009), and any updates thereto.

Effective July 1, 2024, if the Contractor chooses to use a list of diagnosis codes to initially determine whether a service may be an emergency, the MCE must, at a minimum, use the State's Emergency Department Autopay List, accessible from the Code Sets page at in.gov/medicaid/providers. The Contractor must check at a minimum the diagnosis codes in fields 67 and 67A-Q, 69, 70A-C, and 72A-C on the UB04 and 21A-L on the CMS 1500 against the emergency department autopay list.

The Contractor's provider remittance advices for claims reduced to a screening fee shall include a notice alerting providers:

- Where to submit medical records for prudent layperson review.
- That the provider has 120 days to submit medical records for prudent layperson review.
- The location where the provider can find any additional requirements for the submission of medical records for prudent layperson review.

If a prudent layperson review determines the service was not an emergency, the Contractor shall reimburse for physician services billed on a CMS-1500 claim, in accordance with the IHCP Provider Bulletin. Physician services include services provided by an individual

licensed under State law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included (see also: 42 CFR § 414.2).

The Contractor shall reimburse for facility charges billed on a UB-04 in accordance with the IHCP Provider Bulletin, if a prudent layperson review determines the service was not an emergency.

The Contractor shall have the following mechanisms in place to facilitate payment for emergency services and manage emergency room utilization:

- A mechanism in place for a plan provider or Contractor representative to respond within one hour to all emergency room providers twenty-four (24)-hours-a-day, seven (7)-days- a-week. The Contractor will be financially responsible for the post-stabilization services if the Contractor fails to respond to a call from an emergency room provider within one hour.

- A mechanism to track the emergency services notification to the Contractor (by the emergency room provider, hospital, fiscal agent or member's PMP) of a member's presentation for emergency services.

- A mechanism to document a member's PMP's referral to the emergency room and pay claims accordingly.

- A mechanism in place to document a member has made a call to the Contractor's 24-Hour Nurse Call Line twenty-four (24) hours prior to an ER visit, and to waive emergency room copayments for HIP members accordingly, as set forth in Section 3.6.2. This includes a mechanism to communicate the copayment waiver to the emergency services provider.

- A mechanism in place to document a member's referral to the emergency room by the Contractor's 24-Hour Nurse Call Line and pay claims resulting from such referral as emergent.

- A mechanism in place to document a HIP member's inappropriate emergency department utilization, and to communicate emergency room copayments for HIP members accordingly, as set forth in Section 3.6.2.

- A mechanism, and policies and procedures in place for conducting prudent layperson reviews within 30 days of receiving medical records.

- A mechanism and process to accept medical records for a prudent layperson review with an initial claim and after a claim has processed. The Contractor must at a minimum allow a provider to submit medical records for a prudent layperson review within 120 days of a claim's adjudication.

3.6.1 Post-Stabilization Services

As described in 42 CFR 438.114(e), which relates to coverage and payment of post- stabilization care services, and IC 12-15-12, the Contractor shall cover post-stabilization services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition. The Contractor shall demonstrate to FSSA that it has a mechanism in place to be available to all emergency room providers twenty-four (24)-hours-a-day, seven (7)-days-a-week to respond within one hour to an emergency room provider's request for authorization of continued

treatment after the Contractor's member has been stabilized and the emergency room provider believes continued treatment is necessary to maintain stabilization.

The requirements at 42 CFR 422.113(c)(2) and 42 CFR 438.114(e) are applied to the Contractor. The Contractor is financially responsible for post-stabilization services obtained within or outside the network that are pre-approved by a plan provider or Contractor representative. The Contractor is also financially responsible for post-stabilization services that are not pre-approved but administered to a member to maintain the stabilized condition within one (1) hour of the request to the Contractor for pre-approval of further post-stabilization services. The Contractor must also reimburse for post-stabilization services when (i) the Contractor does not respond within one (1) hour to a request for pre-approval, (ii) the Contractor cannot be contacted or (iii) the Contractor and treating physician cannot reach an agreement concerning the members' care and a Contractor physician is not available for consultation. In this situation, per 42 CFR 438.114(e) and 42 CFR 422.113(c)(3), the Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with the care of the patient until a plan physician is reached or one of the following conditions is met:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- A plan physician assumes responsibility for the member's care through transfer;
- A Contractor representative and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

The Contractor shall limit charges to members for post-stabilization care services to an amount no greater than what the Contractor would charge the enrollee if he or she obtained the services through the Contractor per 42 CFR 438.114(e) and 42 CFR 422.113(c)(2)(iv).

3.6.2 Emergency Room Services Co-Payment – HIP

A co-payment will apply to non-emergency use of an emergency room by HIP members. Emergency room care includes care given for a medical emergency when a member believes that their health is in serious danger and every second counts (see also: 42 CFR § 405.440).

Other than HIP members exempt from cost-sharing as described in Section 13.1.4, all HIP members will be subject to a co-payment for all non-urgent use of hospital emergency department services. The member will incur an $8 co-payment for any inappropriate emergency department visit. Providers will collect the co-payment from members, and POWER Account funds cannot be used by the member to pay the co-payment. The Contractor shall include co-payment information on the member's ID card which directs the provider to call the Contractor for specific co-payment amount due, as the member may have received a copay waiver by calling the Contractor's nurse hotline, as described below.

Per IC 27-13-1-8, copayment means an amount, or a percentage of the charge,

that an enrollee must pay to receive a specific service that is not fully prepaid.

All members shall receive an appropriate medical screening examination under section 1867 of the Emergency Medical Treatment and Active Labor Act. The co-payment shall be waived or returned if the member is found to have an emergency condition, as defined in section 1867(e)(1)(A) of the Emergency Medical Treatment and Active Labor Act, or if the member is admitted to the hospital within twenty-four (24) hours of the original visit.

In addition, the member co-payment shall be waived for any member who contacts the Contractor's 24-hour Nurse Call Line prior to utilizing a hospital emergency department. If a member contacts the Nurse Call Line prior to seeking emergency care, the member will not be subject to the prudent layperson review to determine whether an emergency medical condition exists for purposes of applying the co-payment. The Contractor shall have processes in place to communicate emergency department co-payment exemptions on a prospective basis. In addition, the Contractor shall track and monitor whether members who contacted the 24-Hour Nurse Call Line were advised to seek emergency services.

Assuming a member has an available and accessible alternate non-emergency services provider and a determination has been made that the member does not have an emergency medical condition and did call the Contractor's 24-hour Nurse Call Line, in accordance with 42 C.F.R. § 447.54(d), the hospital shall inform the member before providing non-emergency services that:

- The hospital may require payment of the co-payment before the service can be provided;
- The hospital provides the name and location of an alternate non-emergency services provider that is actually available and accessible;
- An alternate provider can provide the services without the imposition of the co- payment; and
- The hospital provides a referral to coordinate scheduling of this treatment.

The Contractor shall instruct its provider network of the emergency room services co-payment policy and procedure, such as the hospital's notification responsibilities (outlined above) and the circumstances under which the hospital shall waive or return the co-payment.

3.7. Behavioral Health

Behavioral health services, with the exception of Medicaid Rehabilitation Option (MRO) and 1915(i) services as described in Section 3.11 Carved-Out Services, are a covered benefit under the HIP program. The Contractor shall be responsible for managing and reimbursing all such services in accordance with the requirements in this section. The Contractor shall provide timely access to behavioral health screening, assessment, referral and treatment services, including outpatient services as well as inpatient psychiatric hospital services, inpatient drug and alcohol detoxification, inpatient drug and alcohol rehabilitation, and residential treatment services for opioid use disorder (OUD) and substance use disorder (SUD) apart from treatment rendered in a State Hospital as described in Section 3.12.3. As described in Section 3.15, the Contractor is encouraged to develop and purchase enhanced services which can provide services in a less restrictive setting and/or which would result in improved outcomes for members. In furnishing behavioral health benefits,

including any applicable utilization restrictions, the Contractor shall comply with the Mental Health Parity and Additions Equity Act (MHPAEA).

In furnishing behavioral health benefits, including any applicable utilization restrictions, the Contractor shall comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) prohibiting the application of more restrictive limits to mental health/substance use disorder benefits than to medical/surgical benefits. Compliance with the MHPAEA and State requirements includes, but is not limited to:

- Not applying any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor) per 42 CFR 438.910(b)(1).

- If a member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits shall be provided to the member in every classification in which medical/surgical benefits are provided per 42 CFR 438.910(b)(2).

- Not applying any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification per 42 CFR 438.910(c)(3).

- Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits. Per 42 CFR 438.910(d), the Contractor shall not impose Non-Quantitative Treatment Limits (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

- Ensuring compliance with MHPAEA for any benefits offered by the Contractor to members beyond those otherwise specified in this Scope of Work.

- Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential members, or contracting provider upon request.

- Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members.

- Providing out-of-network coverage for mental health or substance use disorder benefits. The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-

network providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than those applied for out-of-network medical/surgical benefits in the same classification as required by 42 CFR 438.910(d)(3).

- Coordinating transition of care for members going from a higher to a lower level of care.

- Coordinating transition of care to approved lower level of care for patients who are, due to lack of medical necessity, denied a higher level of care.

The Contractor shall assure that behavioral health services are integrated with physical care services, and that behavioral health services are provided as part of the treatment continuum of care. The Contractor shall develop protocols to:

- Provide care that addresses the needs of HIP members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health;

- Provide a written plan and evidence of ongoing, increased communication between the PMP, the Contractor and the behavioral health care provider; and

- Coordinate management of utilization of behavioral health care services with MRO and 1915(i) services and services for physical health.

3.7.1. Behavioral Health Care Services

The Contractor shall provide all medically necessary community-based, partial hospital and inpatient hospital behavioral health services as identified in Contract Exhibit 2.B. Contractors shall pay CMHCs at a rate not less than the minimum fee schedule established by the State for any covered non-MRO service that the CMHC provides to a HIP member.

The Contractor shall provide behavioral health services through hospitals, offices, clinics, in homes, and other locations, as permitted under state and federal law. A full continuum of services, including crisis services, as indicated by the behavioral health care needs of members, shall be available to members, including partial hospitalization services as described in 405 IAC 5-20-8.

Behavioral health services codes billed in a primary care setting shall be reviewed for medical necessity and, if appropriate, shall be paid by the Contractor.

The Contractor shall allow members to self-refer to any behavioral health care provider in the Contractor's network without a referral from the PMP. Members may also self-refer to any IHCP-enrolled psychiatrist.

The Contractor shall ensure the availability of behavioral health crisis intervention services twenty-four (24) hours a day, seven (7) days a week. The Contractor shall maintain processes for crisis intervention.

3.7.2. Behavioral Health Provider Network

FSSA requires Contractors to develop a sufficient network of behavioral health providers to deliver the full range of behavioral health services. The network shall include psychiatrists, psychologists, clinical social workers and other licensed

behavioral health care providers. In addition, Contractors shall provide inpatient care for a full continuum of mental health and substance abuse diagnoses. See Section 5.2 for behavioral health network requirements. All services covered under the clinic option shall be delivered by licensed providers and qualified behavioral health professionals working under a licensed behavioral health provider as defined in 405 IAC 5-20-8-2.

The Contractor shall train its providers in identifying and treating members with behavioral health disorders, and shall train PMPs and specialists on when and how to refer members for behavioral health treatment. The Contractor shall also train providers in screening and treating individuals who have co-existing mental health and substance abuse disorders. The Contractor is responsible for ensuring that its behavioral health network providers are trained about and are aware of the cultural diversity of its member population and are competent in respectfully and effectively interacting with individuals with varying racial, ethnic and linguistic differences. The Contractor shall provide to FSSA its written training plan, which shall include dates, methods (e.g., seminar, web conference, etc.) and subject matter for training on integration and cultural competency.

Members shall be able to receive timely access to medically necessary behavioral health services. The network shall meet the access requirements specified in Section 5.2.5.

3.7.3. Case Management for Members Receiving Behavioral Health Services

The Contractor shall employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services. At a minimum, the Contractor shall offer to provide complex case management services to any member at risk for inpatient psychiatric or substance abuse hospitalization, and to members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization. Case managers shall contact members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization, and shall schedule an outpatient follow-up appointment to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge.

Case managers should use the results of health needs screenings and more detailed comprehensive health assessments, including the medically frail health assessments, to identify members in need of case management services. Case managers shall also monitor members receiving behavioral health services who are new to the Contractor's plan to ensure that the member is expediently linked to an appropriate behavioral health provider. The case manager shall monitor whether the member is receiving appropriate services and whether the member is at risk of over- or under-utilizing services. FSSA shall provide access to its web-based interface *Core*MMIS to allow the Contractor to monitor MRO utilization, which is covered by Medicaid FFS.

Case managers shall regularly and routinely consult with both the member's physical and behavioral health providers to facilitate the sharing of clinical information, and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member.

In addition, with the appropriate consent, case managers shall notify both PMPs and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. Case managers

shall provide this notification within five (5) calendar days of the hospital admission or emergency treatment.

Documentation of case management procedures, contacts, interventions and outcomes shall be made available to FSSA upon request.

3.7.4. Behavioral Health Care Coordination

The Contractor shall ensure the coordination of physical and behavioral health care among all providers treating the member. The Contractor shall coordinate services for individuals with multiple diagnoses of mental illness, substance abuse and physical illness. The Contractor shall have policies and procedures in place to facilitate the reciprocal exchange of health information between physical and behavioral providers treating the member.

The Contractor shall share member medical data with physical and behavioral health providers and coordinate care for all members receiving both physical and behavioral health services, to the extent permitted by law and in accordance with the member's consent, when required. The Contractor shall contractually mandate its behavioral health care to provide member records to the Contractor upon request. Disclosure of mental health records by the provider to the Contractor and to the member's physician is permissible under the Health Insurance Portability and Accountability Act (HIPAA) and state law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance abuse records. The Contractor shall contractually require every network provider, including behavioral health providers, to ask and encourage members to sign a consent that permits release of substance abuse treatment information to the Contractor and to the PMP or behavioral health provider, if applicable.

Contractors shall, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The behavioral health profile lists the physical and behavioral health treatment received by that member during the previous reporting period. Information about substance abuse treatment and HIV/AIDS should only be released if member consent has been obtained.

For each member receiving behavioral health treatment, the Contractor will contractually require behavioral and physical health providers to document and reciprocally share the following information for that member:

- Primary and secondary diagnoses;
- Findings from assessments;
- Medication prescribed;
- Psychotherapy prescribed; and
- Any other relevant information.

Contractors shall, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs, and shall provide physical health and other medical information to the appropriate CMHC for every member.

The Contractor shall implement mechanisms to ensure coordination among member's providers. With appropriate consent, the Contractor shall notify behavioral health providers and medical providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. This notice must be provided within five (5) calendar days of the hospital inpatient admission or emergency treatment. The Contractor shall maintain a description of

strategies proposed to receive hospital notification of inpatient admissions to facilitate meeting the requirement for example, through the use of incentive programs. The Contractor shall develop additional mechanisms for facilitating communication between behavioral health and physical health providers to ensure the provision of integrated member care. Incentive programs, case managers, behavioral health profiles, etc. are potential mechanisms to ensure care coordination and the reciprocal exchange of health information between physical and behavioral health providers. The Contractor shall require the behavioral health provider to share clinical information directly with the member's PMP. The Contractor shall evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes. Refer to Section 3.13 for notification and continuity of care requirements for non-behavioral health admissions and emergency services.

The Contractor must develop mechanisms for facilitating communication between behavioral health and physical health providers to ensure the provision of integrated member care. The Contractor shall maintain mechanisms for ensuring physical and behavioral health integration and information sharing.

The Contractor shall evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes. Documentation of integration policies and procedures and outcomes data shall be made available to FSSA upon request and at minimum on a semi-annual basis. Additionally, the State is exploring implementation of new initiatives for behavioral and physical health integration for Indiana Medicaid members. The Contractor shall participate in the planning and execution of State-driven integration at the direction of FSSA.

Documentation of integration policies and procedures, contacts, behavioral health profile templates and outcomes data shall be made available to FSSA upon request.

3.7.5 Behavioral Health Continuity of Care

The Contractor shall utilize behavioral health case managers to monitor the care of members receiving behavioral health services who are new to the Contractor or who are transitioning to another MCE or other treatment provider, to ensure that medical records, treatment plans and other pertinent medical information follows each transitioning member. The Contractor shall notify the receiving MCE or other provider of the member's previous behavioral health treatment, and shall offer to provide to the new provider the member's treatment plan, if available, and consultation with the member's previous treating provider. The Contractor and receiving MCE shall coordinate information regarding prior authorized services for members in transition.

The Contractor shall require, through provider contract provisions, that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment shall be provided within seven (7) calendar days from the date of the member's discharge. If a member misses an outpatient follow-up or continuing treatment, the Contractor shall ensure that a behavioral health care provider or the Contractor's behavioral health case manager contacts that member within three (3) business days of notification of the missed appointment.

3.7.6 Institution for Mental Disease (IMD)

The Contractor will cover short term stays in an Institution for Mental Diseases (IMD) for serious mental illness (SMI) and substance use disorder (SUD) under the State's §1115 SMI and SUD demonstration authorities. IHCP will follow federal guidance in accordance with 42 CFR 435.1010 as well as any additional criteria established by the State's §1115 waivers used to distinguish qualified IMD providers.

In accordance with 42 CFR 457.1201(e) and 42 CFR 438.3(e)(2)(i)-(iii), the State has determined that treatment in an IMD is a medically appropriate and cost-effective substitute for the behavioral health service covered under the State Plan in other settings. Contractors may, but are not required, to use an IMD in lieu of other behavioral health services. The Contractor is prohibited from requiring an enrollee to access behavioral health services at an IMD.

The State will make monthly capitation payments to the Contractor to cover short term inpatient stays for serious mental illness (SMI) in a qualified Institution for Mental Disease (IMD) for members aged 21 to 64 and is required to maintain an average length of stay not to exceed 30 days for all IMD stays for SMI. A maximum of 60 days can be approved, if medically necessary, for short term IMD stays for SMI.

The Contractor will cover short term inpatient stays for SUD in a qualified Institution for Mental Diseases (IMD) for members aged 21 to 64 for up to 15 days in a calendar month as medically necessary for individuals with SUD. If a member's IMD stay exceeds 15 days in a calendar month and the member is awaiting placement in a state operated facility (SOF) for treatment, the member will be disenrolled from the plan and enrolled in fee for service. For stays exceeding 15 days in a calendar month in which the member is not awaiting placement in a SOF, the member will remain enrolled with the Contractor and the state shall recover the entire monthly capitation payment for the member.

The Contractor will cover short term crisis residential stays for substance use disorder (SUD) in a qualified Institution for Mental Diseases (IMD) for members aged 21 to 64 and is required to maintain an average length of stay not to exceed 30 days for all residential IMD stays for SUD.

The Contractor shall actively track and coordinate the care of members receiving care in an IMD. Anticipating and planning for a member's successful discharge should begin immediately upon a member's entry into an IMD.

Lists of qualified IMD providers under both §1115 waivers will be provided to the Contractor.

The Contractor may not require or create incentives for the member to receive services in an IMD versus a setting covered under the State Plan.

In accordance with 42 CFR 435.1010, an IMD is generally defined as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental

diseases." This may include a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services. The Contractor will be responsible for reviewing and understanding all specific State criteria to distinguish qualifying IMDs under both SMI and SUD §1115 demonstrations as well as all related State guidance.

The Contractor must submit data related to IMD stays as outlined in the MCE Reporting Manual.

The proposed services and settings will be reimbursable and subject to the requirements contained in 42 CFR 438.6(e).

3.8 Care Coordination

Prior to Contract start date and on an annual basis, the Contractor shall submit for approval to the State a Care Coordination Operational Plan. The Contractor must receive approval before member stratification. The operational plan shall include, but not limited to, the following: care coordination team member roles, care coordination team organizational chart, team member training requirements, team member educational and/or experience requirements, screening tool, stratification methodology (including, caseload ratios per stratification level), reassessment frequency, and care plan components. The Contractor's care coordination operational plan and service delivery must contain evidence of person-centered practices in all aspects. In addition, the care coordination plan may be modified if the Contractor receives written approval from FSSA.

The Contractor shall implement a transition of care policy that is consistent with federal requirements and at least meets the State defined transition of care policies in the HIP MCE Policies and Procedures Manual per 42 CFR 438.62(b)(1)-(2). In accordance with 42 CFR 438.208(b)(2)(i)-(iv) and 42 CFR 438.208(b)(4), the Contractor shall implement procedures to coordinate:

- Services the Contractor furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;
- Services the Contractor furnishes to the member with the services the member receives from any other MCE or health plan;
- Services the Contractor furnishes to the member with the services the member receives in FFS Medicaid;
- Services the Contractor furnishes to the member with the services the member receives from community and social support providers; and
- Sharing results of any identification of member needs from assessments with the State or other health plans.

3.8.1 Member Assessment

3.8.1.1 Initial Screening

In accordance with 42 CFR 438.208(b)(3), the Contractor shall conduct an initial screening of each member within ninety (90) calendar days of the effective date of enrollment to identify the member's immediate physical

and/or behavioral health care needs. Notwithstanding the foregoing, the Contractor shall use best efforts to conduct the initial screening of individuals identified as potentially medically frail as soon as practicable prior to the expiration of the member's Verification Period. The Contractor must make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful. The Contractor shall make attempts to find a member's current contact information if it is not included in the enrollment file. The initial screening will also determine the need for disease management, care management, complex case management, or RCP services as detailed in Section 3.8.2. The Contractor shall utilize the FSSA Health Needs Screening tool.

During the initial screening, and periodically thereafter, the Contractor will review the member's claims history, identify access or accommodation needs, language barriers, or other factors that might indicate that the member requires additional assistance. The initial screening shall also identify members who have complex or serious medical conditions that require an expedited appointment with an appropriate provider. The initial screening will ensure that members who are in ongoing treatment receive assistance in accessing appropriate care in order to avoid disruptions in services. The initial screening must include a full review of important relevant clinical information such as the provider's assessment of conditions and the severity of illness, treatment history and outcomes, other diseases, illnesses, and health conditions as well as the member's psychosocial, support, behavioral health and treatment needs.

At minimum, the initial screening shall:

- Utilize claims data, health information exchange data, information gathered in the screening, medical records and other sources to ensure care coordination and management;
- Identify gaps in member's care and facilitate communication to relevant providers, including the member's PMP, if applicable;
- Identify immediate physical and/or behavioral health needs;
- Determine need for care coordination and management;
- Conduct comprehensive review of clinical history;
- Perform stratification based on initial assessment and historical claims data;
- Determine clinical, psychosocial, functional and financial needs with appropriate referrals to community-based organizations or MCE programs;
- Gather information regarding level and type of existing care management; and
- Review information to identify member's care strengths, needs and available resources to enable person-centered planning in conjunction with the member.

The initial screening may be conducted in person, by phone, electronically through a secure website, or by mail. Incomplete initial screenings completed electronically through the Contractor's secure website will receive follow up telephone contacts to promote completion of the initial health screening. The Contractor shall develop procedures and provide documentation of methods to be used to maximize contacts with members in order to complete the initial screening required in this section.

Based on the results of the initial screening, the Contractor shall stratify members into the appropriate service category - those members requiring disease management, care management, complex case management, or RCP, in accordance with Section 3.8.2. After stratifying the member to an appropriate care level, the Contractor shall provide ongoing disease management, care management, complex case management, or RCP, as appropriate. The State reserves the right to require the Contractor to adjust its stratification protocol, with reasonable notice, to ensure the most effective care coordination is available for members.

In addition to the initial screening conducted by the Contractor, the Contractor shall also develop strategies to encourage the contracted provider network to utilize screening tools to identify at-risk members. These provider-driven tools shall not duplicate or replace the Contractor conducted screenings. The Contractor shall maintain strategies to facilitate implementation of provider-driven screening tools including methods to encourage usage, processes to communicate results to the Contractor and the proposed tool(s).

3.8.1.2 Comprehensive Health Assessment

In accordance with 42 CFR 438.208(c)(1)-(2), the Contractor shall implement mechanisms to comprehensively assess each member identified as having special health care and/or long-term services and supports (LTSS) needs to identify any ongoing special conditions of the member that require a course of treatment, program change, or regular care monitoring. The Contractor shall conduct a comprehensive health assessment of all members initially stratified into care management, complex case management or RCP following the initial screening in order to further identify the appropriate level of care coordination services. The comprehensive health assessment will be all-inclusive and identify the clinical, psychosocial, functional and financial needs of the member to ensure appropriate referrals to MCE program and community-based organizations. The comprehensive health assessment shall be completed within one hundred and fifty (150) calendar days of enrollment, and will be used to develop and implement a comprehensive care plan to meet the member's needs.

The Contractor will develop and maintain a Comprehensive Health Assessment to be approved by FSSA. The Contractor's Comprehensive Health Assessment must contain, at a minimum, elements prescribed by FSSA and may be augmented with condition specific and/or Contractor specific elements. The assessment tool may differ for children/adolescents and adults. Results of the Child and Adolescent Needs and Strength (CANS) assessment process should inform the child's treatment plan, provide level of care decision support, serve as an outcome measurement and facilitate communication between agencies.

The Contractor will collect and review medical and educational information, as well as family and caregiver input, as appropriate, to identify the member's care strengths, health needs and available resources. The comprehensive assessment may include, but is not limited to, a review of the member's claims history and/or contact with the member, member's family, PMP (if applicable), or other significant providers. A clinician on the Contractor's care management team will review the findings of the health assessment and provide the findings to the member's primary providers, including the member's PMP and/or behavioral health care providers, if applicable. If the Comprehensive Health Assessment is used to affirm a member's medically frail designation, in which case, the Contractor shall report to the State in the form and manner prescribed in Section 12.3.2.

The Contractor must maintain methods to maximize contacts with members in order to complete the comprehensive health assessments required in this section.

3.8.1.3 Identification and Assessment of Pregnant Women

The Contractor shall implement methods to promptly identify members who become pregnant. All identified pregnant women shall have a comprehensive risk assessment completed. The Contractor shall offer all identified pregnant women care coordination services, either care management or complex case management. Identified pregnant women who opt out of care coordination services will receive, at a minimum, monthly contacts from the Contractor through the end of the pregnancy. If the Contractor is unable to contact the pregnant woman during the monthly attempt, the Contractor shall contact the member's provider and make other attempts, including the use of Community Health Workers, to physically make contact. These contacts must be documented by the Contractor and available for State review as requested.

The Contractor shall provide all pregnant women assessed as utilizing either tobacco or tobacco products information regarding the availability of tobacco cessation services through the Indiana Quitline.

Further, FSSA has implemented a Notification of Pregnancy (NOP) process that encourages MCEs and providers to complete a comprehensive risk assessment (i.e., an NOP form) for pregnant members. The Contractor shall comply with the policies and procedures set forth in the IHCP Provider Bulletin regarding the NOP process dated February 21, 2023 (BT202312), and any updates thereto.

The provider will be responsible for completing the standard NOP form, including member demographics, any high-risk pregnancy indicators, and basic pregnancy information. The member's pregnancy must be less than thirty (30) weeks gestation at the time of the office visit on which the NOP is based. The Contractor receiving the NOP shall contact the member to complete a comprehensive pregnancy health assessment within twenty-one (21) calendar days of receipt of completed NOP form from the provider. The Contractor shall also gather clinical data from relevant health information exchanges to supplement claims data mining, NOPs, and self-reports of pregnancy. Only one assessment should be completed per member per pregnancy. NOP requirements and conditions for payment are set forth in the HIP Policies and Procedures Manual.

To be eligible for the provider incentive payment, the NOP form must be submitted by providers via the IHCP Provider Healthcare Portal within five (5) calendar days of the visit during which the NOP form was completed. The State shall reimburse the Contractor for NOP forms submitted according to the standards set forth in the HIP Policies and Procedures Manual. This reimbursement amount must be passed on to the provider who completed the NOP form.

The Contractor shall have systems and procedures in place to accept NOP data from the State's fiscal agent, assign pregnant members to a risk level and, when indicated based on the member's assessment and risk level, enroll the member in care coordination. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the IHCP Provider Healthcare Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent.

3.8.2 Stratification & Level of Service

Based on the results of the initial screening as well as mining of historical claims data and clinical data from health information exchanges, the Contractor shall stratify its membership into various subpopulations to identify member level of service and ensure continuity of care. The outcome of the member assessment set forth above in Section 3.8.1 will determine the member's needs in the stratification process resulting in the member's assignment to one of the levels of care coordination service, set forth below in this section.

3.8.2.1 Disease Management Level of Service

Disease management is intended to help guide the care of members with chronic health conditions to improve the quality of care, adherence to care and control health care costs. Supporting the practitioner-member relationship and plan of care, the disease management program will emphasize the prevention of the exacerbation of the condition and its complications using evidenced based practice guidelines.

The Contractor shall offer, at minimum, sickle cell disease, asthma, depression, pregnancy, attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), chronic obstructive pulmonary disease (COPD), coronary artery disease, chronic kidney disease, congestive heart failure, hypertension, diabetes, and SUD disease management programs for eligible members. The Contractor may propose, for FSSA approval, programs for additional conditions. Members with excessive utilization or under-utilization for conditions other than those listed shall also be eligible for the disease management level of service described in this section.

OMPP reserves the right to require the Contractor to have disease management programs for additional conditions in the future. OMPP will provide three (3) months advance notice to the Contractor if OMPP decides to add new diseases to the disease management program requirements.

Disease management services should assist members in understanding their chronic conditions, set goals, and achieve self-selected outcomes through education, counseling, and on-going support. The Contractor will provide a customer call line for provider and community information, linkage to community resources and disease specific and general preventive health

education and reminders for members. Disease management services must be provided to members with specific conditions and for prevention of related conditions. For example, disease management services for members diagnosed with diabetes or hypertension must include education for the member on kidney disease and the benefits of having evaluations and treatment for chronic kidney disease.

Disease management services may be provided by non-clinical staff with escalation to clinical staff as indicated by provider request or change in clinical status. Through disease management services, the Contractor will provide information and specific preventive care reminders, resources, and referrals as requested by members, member advocates, and health care providers. The Contractor will promote evidenced-based practices for chronic disease conditions.

The Contractor will provide information, resources and referrals as needed to all members, their families and health care providers, as requested. Disease management services shall include policies and procedures that encourage all new members to have a preventive care visit within sixty (60) calendar days of the member's effective date of enrollment and ongoing member outreach as indicated for the entire population.

Disease management services shall address each member's medical and health concerns, specific medical information, and available community resources. Services will typically result in brief, short-term encounters. The Contractor will reach out to members and providers during the initial assessment period as well as on an ongoing basis, via phone, in person and through written notification, as well as through the use of community health workers, to physically make contact when members cannot be reached or when disease management via phone is not successful. Members in disease management services will be provided with contact phone numbers at the Contractor to call with questions.

3.8.2.2 Care Management Level of Service

The care management level of service is intended for members who need assistance with care coordination, making preventive care appointments or accessing care to address the members' chronic health condition(s). Care management is provided to help guide the member with access to care for needed health or social services to address the member's chronic health condition(s).

Care management is a purposeful plan to reach members and impact their health and health care utilization, and to coordinate all services provided to members. Through care management, the Contractor assists members in improving their health outcomes. Members who are at risk for an acute or catastrophic episode in the future may be prioritized for complex case management services. In the interim care management services will be provided as a preventive measure. The Contractor will provide comprehensive coordination services that are tailored to the individual, rely on sound medical practices, and include Medicaid-covered services. All members identified for care management services will receive all of the benefits of disease management services in addition to the additional care management supports.

Newly referred members and persons with newly diagnosed conditions, increasing health services or Emergency services utilization, Emergency room utilization at least three (3) standard deviations outside of the mean for the population group, evidence of pharmacy non-compliance for chronic conditions, members with special health care needs, members designated as medically frail, individuals recently discharged from an Institution for Mental Disease (IMD), individuals with conditions of interest that FSSA has identified to the Contractor and/or members with member request that indicate the need for real-time, proactive intervention shall be referred and contacted telephonically or in person by a care manager or community health worker for enrollment in care management services including direct consumer contacts to assist members with scheduling, location of specialists and specialty services, transportation needs, twenty-four (24)-hour nurse call line use, general preventive (e.g. mammography) and disease specific reminders, pharmacy refill reminders, tobacco cessation and education regarding use of primary care and Emergency services.

The Contractor must make every effort to contact members in care management by telephone. The Contractor shall use community health workers to physically make contact when members cannot be reached via telephone within a predetermined, State approved timeframe. Should such attempts fail, the Contractor shall develop a plan for how to reach members (including outreach to providers, repeated physical outreach, etc.). Materials should be delivered to the member in a manner in accordance with the member's selection as outlined in Section 4.3, either through postal or electronic means direct to the consumer. Educational materials and telephonic contacts may utilize web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth-grade reading level and in accordance with all member communication requirements outlined in Section 4.3, and should be sent to members no less than quarterly. The Contractor shall consider utilizing the services of community health workers, as appropriate, to outreach to and provide information to those members participating in care management. The Contractor will be required to submit quarterly and annual data to document the number of persons receiving care management services, including the number of active and passive contacts made to the member.

At the time they are enrolled, members may already be receiving case management services through the CMHCs. As such, the Contractor will work with the member and CMHC to determine where and how the member should receive care coordination or case management services. For example, the Contractor will work with the member and/or the member's provider(s) to decide whether the member will receive care coordination and case management services from the Contractor, from the CMHC, or both. In all cases, the CMHC and Contractor should work closely together to ensure the member receives appropriate services that are not duplicated.

3.8.2.3 Complex Case Management (Member Focus) Level of Service

Complex case management with member focus involves the active coordination of care and services with the member and between providers while navigating the extensive systems and resources required for the member. It includes comprehensive assessment, determination of available benefits, development and implementation of a complex case management plan directed at the member's chronic health conditions. Complex case

management targets members with two (2) or more disease states who need assistance with care coordination, making preventive care appointments or accessing care to address the members' chronic health condition or members who have had an inpatient hospital stay in the last ninety (90) days or members with high dollar claims of over fifty thousand $50,000 thousand dollars (>$50,000) in six (6) months. The focus is on working with the providers to meet the needs of the individual through communication with the member, PMP (if applicable), other providers, and the member's natural support system. The member's active involvement will help members gain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

At a minimum, the Contractor must provide complex case management services for members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization. The Contractor must also provide complex case management services for any member at risk for inpatient psychiatric, drug overdose, or substance abuse re-hospitalization. Care managers must contact members during an inpatient hospitalization, or as soon as practicable upon receiving notification of a member's inpatient behavioral health hospitalization. The care manager must work with the hospital discharge planner, behavioral health provider case manager and/or natural supports (i.e. family) to ensure that an outpatient follow-up appointment is scheduled to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge. The Contractor must ensure that lack of transportation is not a barrier to the member attending the appointment.

Complex case management includes all of the services and benefits from disease management and care management. The Contractor shall use community health workers, to physically make contact when members cannot be reached via telephone within a predetermined, State approved timeframe. Should such attempts fail, the Contractor shall develop a plan for how to reach members (including outreach to providers, repeated physical outreach, etc.). All members in complex case management with member focus must receive materials no less than monthly. Avoidance of unnecessary Emergency department and inpatient hospitalizations and increased use of preventive health care are goals for complex case management.

3.8.2.4 Complex Case Management (Provider Focus) Level of Service

Complex case management with a provider focus is appropriate for members who either choose not to be actively involved or are unable to actively participate in their health care. Complex case management targets members with two (2) or more disease states who need assistance with care coordination, making preventive care appointments, or accessing care to address the members' chronic health conditions or members who have had an inpatient hospital stay in the last ninety (90) days or members with high dollar claims of over fifty thousand dollars (>$50,000) in six (6) months. The focus is on working with the providers to meet the needs of the individual through communication with the PMP (if applicable), other providers, and the member's natural support system. The goal is to help members gain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

Complex case management with provider focus is the active coordination by the Contractor of care and services between providers while navigating the extensive systems and resources required for the member. It involves comprehensive assessment, determination of available benefits, development and implementation of a complex case management plan directed at the chronic health conditions.

At a minimum, the Contractor must provide complex case management services for members discharged from an inpatient psychiatric, drug overdose, or substance abuse hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization discharge. The Contractor must also provide complex case management services for any member at risk for inpatient psychiatric or substance abuse re-hospitalization. Care managers must contact members during an inpatient hospitalization or as soon as practicable upon receiving notification of a member's inpatient behavioral health hospitalization. The care manager must work with the hospital discharge planner, provider case manager and/or natural supports (i.e. family) to ensure that an outpatient follow-up appointment is scheduled to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge and transportation is not a barrier to attending the appointment.

Complex case management with provider focus includes all of the services and benefits from disease management and care management. In addition, all members receiving provider focused complex case management services must receive materials no less than six (6) times a year. Avoidance of unnecessary Emergency department and inpatient hospitalizations and increased use of preventive health care are goals for complex case management.

3.8.2.5 Right Choices Program Level of Service

The Right Choices Program (RCP) is Indiana's restricted card program. The purpose of the RCP is to identify members who use covered services more extensively than their peers and/or exhibit drug-seeking behaviors. The program, set forth in 405 IAC 1-1-2(c) and 405 IAC 5-6, is designed to monitor member utilization, and when appropriate, implement restrictions for those members who would benefit from increased care coordination. The RCP follows the CMS design of a Patient Review and Restrict (PRR) program that is focused on behaviors of Doctor Shopping and excessive utilization of Controlled Substances, especially Opioids. The Contractor will provide appropriate disease management, care management or complex case management services to the RCP members.

Program policies, set forth by the FSSA for the RCP, are delineated in the Right Choices Program Policy Manual. The Contractor shall comply with the program policies set forth in the Right Choices Program Policy Manual, which is provided on the State "Manuals" page (https://www.in.gov/medicaid/partners/medicaid-partners/managed-care-health-plans/mce-secure-landing-page/mce-manuals/). The Contractor shall be responsible for RCP duties for their members, as outlined in the Right Choices Program Policy Manual, including, but not limited to, the following:

- Evaluate claims, medical information, referrals and data to identify members to be enrolled in the RCP. Before enrolling a member in the RCP, the Contractor must ensure a physician, pharmacist or nurse confirms the appropriateness of the enrollment;
- Document member enrollment and compliance in Portal;
- Enroll members in the RCP;
- Provide written notification of RCP status to such members and their assigned primary physicians and pharmacies;
- Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management and care coordination with the goal of modifying member behavior;
- Provide appropriate customer service to providers and members;
- Evaluate and monitor the member's compliance with his or her treatment plan to determine if the RCP restrictions should terminate or continue;
- Notify FSSA of members that are being reported to the FSSA Bureau of Investigation for suspected or alleged fraudulent activities;
- Provide ad-hoc reports about RCP to FSSA upon request;
- Cooperate with FSSA in evaluation activities of the program by providing data and/or feedback when requested by FSSA;
- Meet with FSSA about RCP program implementation as requested by FSSA; and
- Develop, for FSSA approval, and implement internal policies and procedures regarding the Contractor's RCP program administration.

FSSA shall monitor the Contractor's compliance with the RCP duties set forth in this Scope of Work and the Right Choices Program Policy Manual through its monthly onsite visits and/or external quality review activities. The Contractor may be subject to the non-compliance remedies as set forth in Exhibit 2.B if the Contractor fails to comply with the RCP duties set forth in this Scope of Work and the Right Choices Program Policy Manual. FSSA OMPP reserves the right to review pharmacy and emergency room utilization figures for the Contractor's RCP membership, including the number of RCP members who have had more than one emergency room visit in a thirty (30)-calendar day period, in assessing the effectiveness of the Contractor's RCP program administration.

3.8.3 Care Plan Development

After the initial assessment and stratification, the Contractor shall assign members to a care level, develop a care plan for each member, and facilitate and coordinate the holistic care of each member according to his or her needs. The Contractor shall utilize a person-centered care plan development planning process, developed in accordance with any applicable State quality assurance and utilization review

standards. The member or guardian must sign off on the care plan and the plan must be approved by the Contractor in a timely manner per 42 CFR 438.208(c)(3)(iii)-(v). All identified pregnant women who agree to either care management or complex case management shall have a care plan developed in conjunction with the Contractor.

The Contractor will use data from multiple sources in the development of each member's care plan, including, at minimum, claims data, data collected during the initial screening, the follow-up comprehensive health assessment, available medical records, clinical data from health information exchanges, Indiana Scheduled Prescription Electronic Collection & Tracking (INSPECT) and any other sources, to ensure that the care for members is adequately coordinated and appropriately managed. Through data analysis and predictive modeling, the Contractor will identify members who are at the highest risk for hospitalization or relapse, or high cost and/or high utilization in the future. In addition, the Contractor will gather information about the level and type of existing care and/or case management services that the member may already be receiving, for example, through a CMHC. The Contractor will use the information to identify gaps in the member's current treatment approach, and communicate those findings to the member's PMP (if applicable) or another appropriate physician.

The Contractor will assist the member, the member's family and the member's physician(s) to develop a care plan with specific objectives, goals and action protocols to meet identified needs. The Contractor will initiate and facilitate specific activities, interventions and protocols that lead to accomplishing the goals set forth in the care plan, and shall be responsible for developing strategies to facilitate timely and secure communication and information sharing between providers, caregivers, and stakeholders.

The care plan will include, at a minimum:

- Clinical history and pertinent family history;
- Diagnosis(es);
- Functional and/or cognitive status;
- Medical Equipment and Medical Equipment Suppliers;
- Immediate service needs;
- Use of services not covered by the program;
- Accommodation needs (e.g., special appointment times, alternative formats) and auxiliary aids and services;
- Barriers to care (i.e. language, transportation, etc.);
- PMP, if applicable;
- Care/case manager from a service delivery system, for members with one;
- Psychosocial support resources;
- Local community resources;
- Family member/caregiver/facilitator resources and contact information;
- Behavioral health status;
- Intensity of services;
- Assigned case coordinator for disease management, care management, complex case management, or RCP;
- Member self-management goals;
- Clearly identified, member-centered, and measurable long-term goals and objectives;
- Clearly identified, member-centered, and measurable short-term goals and objectives;

- Key milestones towards meeting short-term and long-term goals and objectives;
- Planned interventions and contacts with member, providers and/or service delivery system; and
- Assessment of progress, including input from family, if appropriate.

The Contractor will have standard protocols in place to assess, plan, implement, re-assess and evaluate members, minimally including:

- Pain;
- Trouble sleeping;
- Anxiety / depression;
- Medications – poly-pharmacy and gaps in prescription refills;
- Skin;
- Bowel / bladder;
- Transitions;
- Health Maintenance – preventive care;
- Health Maintenance – chronic disease management;
- Mobility;
- Nutrition;
- Advance care planning;
- Caregiver burden;
- Oral health;
- Physical and sexual abuse;
- Avoiding unwanted pregnancy;
- Preventing choking from inappropriate supervision with eating; and
- Appropriate gait evaluation and adaptive equipment use to prevent fractures.

When developing the care plan, in addition to working with a multidisciplinary team of qualified health care professionals, the Contractor must ensure that there is a mechanism for members, their families (including biological, foster, or adoptive, as appropriate), or others chosen by the member to be actively involved in the care plan development. The Contractor will provide necessary information and support to allow the individual to participate and to actively engage in the process. The care plan must reflect cultural considerations of the member. In addition, the care plan development process must be conducted in plain language, and be accessible to the disabled and limited English proficient. The Contractor must ensure that the care management plan is provided to the member's PMP (if applicable) or other significant providers. The Contractor must also provide the member the opportunity to review the care plan as requested.

Services called for in the care plan will be coordinated by the Contractor's care coordination staff, in consultation with any other care managers already assigned to a member by another entity (i.e. CMHC, county, provider, or a treatment facility). The Contractor's care managers for Complex Case Management and RCP must be licensed physician assistants, registered nurses, therapists or social workers and have training, expertise and experience in providing case management and care coordination services for individuals with complex health needs, including individuals with behavioral health needs and/or developmental disabilities. The Contractor's care managers will work in partnership with a member's providers and other caregivers to ensure that the members' overall care is coordinated and well managed. Each member will have an assigned care manager, and each of the Contractor's care managers may be assigned to multiple members. However, for Complex Case Management and RCP, the member to coordinator ratio will not exceed 50:1, unless otherwise approved in writing by the State.

Care plans will delineate a variety of "low touch" and "high touch" interventions and approaches ranging from member educational mailings, telephone contacts with members and providers, face-to-face visits, in-home visits, and telephonic outreach. Interventions may range from passive mailings for preventive care reminders to home visits by the care manager. The Contractor shall maintain a State approved care plan and indicate which interventions and approaches will be used. The care plan shall also describe successful interventions and approaches used to gain maximum benefit for each care coordination stratification level.

Care plans shall be generally developed in accordance with the member's current level of service stratification level, as detailed below.

3.8.3.1 Disease Management Care Plans

Disease management care plans may be fairly basic or more involved depending on member needs. The simplest of plans would contain documentation of a member's stratification level, the condition(s) for which the member should receive disease management, the schedule of disease management interventions for those conditions, and contact information for the member's primary provider(s). Disease management care plans must include a schedule for distributing disease state related information, prevention and appointment reminders as well as an annual review.

3.8.3.2 Care Management Care Plans

Care management care plans will include all elements of disease management. The care plan will identify the problems, barriers and issues related to the individual's health care needs. It will address goals, objectives and interventions to meeting the needs of the individual. The Contractor will use a multi-disciplinary team skilled in nursing, social work and behavioral health, with knowledge of local community resources to implement protocol-driven care modules for members. This will include action steps to be followed when needs are identified. This team is responsible for the initial assessment and on-going re-assessment and evaluation of care management members.

Care plans should anticipate volatile healthcare needs, including a need for immediate respite, medical advice or home health care. Care management care plans should foresee possible crisis situations where immediate additional support is needed to prevent hospitalizations, long-term care or poor outcomes. The Care Plan must describe how the Contractor will manage care for these members, including after business hours.

The Contractor will engage the member's PMP (if applicable) or other significant provider(s) in care management through ongoing, direct interaction between the provider and the multidisciplinary care management team.

3.8.3.3 Complex Case Management Care Plans

Complex case management services are defined by multiple medical needs, high risk issues such as significant deterioration in health status or ongoing lack of self-management skills due to personal issues, cognitive impairment, mental illness, lack of social supports, or multiple co-morbidities. Complex case management care plans will include all elements of disease

management and care management, as well as higher levels of support. The Medical Director shall be available to consult with the clinicians on the case management team as needed to develop the care plans for high-risk cases. The Contractor will use a multi-disciplinary team skilled in nursing, social work and behavioral health, with knowledge of local community resources to implement protocol-driven care modules for members. Care plans will delineate the frequency and mode of contacts with members, minimally monthly. Care plans will incorporate additional expertise as needed based on the person's health conditions, disabilities, pharmacy, and other urgent management needs.

Care plans should anticipate volatile healthcare needs, including a need for immediate respite, medical advice or home health care. Home health care is defined as limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services (see also: 42 CFR § 440.70).

Care plans should foresee possible crisis situations where immediate additional support is needed to prevent hospitalizations, long-term care or poor outcomes. The Contractor shall manage care for these members, including after business hours.

The Contractor will provide complex case management through consultation services with the PMP (if applicable) and other providers to facilitate communication, engaging providers, maximizing the providers' ability to manage disease, minimizing providers' use of unnecessary referrals and reducing the need for hospitalization and ER utilization. Care plans for complex case management services must include a schedule for contact with the PMP (if applicable) and other providers. In crisis situations, contact with the member, PMP (if applicable) and other providers is expected to be immediate, frequent and intense and not less than monthly.

The Contractor will engage the member's PMP (if applicable) and other significant providers in complex case management activities through ongoing, direct interaction between the provider(s) and the multidisciplinary care management team.

The Contractor will assertively engage members and providers in the development of a complex case management plan to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. The member may choose to become actively engaged in learning about their health condition(s) and participating with their medical team through the member focused approach. In the alternative, a member may be unable to actively participate or may choose to remain more passive, in which case, the provider focused approach would be more appropriate. Each approach for the development of complex case management care plans is detailed below.

3.8.3.3.1 Complex Case Management - Member Focus

Care plans for members who actively participate in case management and in need of complex case management services will include a focus on communication with the PMP (if applicable), other

providers, and the member's natural support system, with emphasis on the responsibilities and actions of the member. The complex case management plan will identify the problems, barriers and issues related to the individual's health care needs and identify strategies for best engaging the member in his/her own treatment. It will address goals, objectives and interventions to meeting the needs of the individual.

3.8.3.3.2 Complex Case Management - Provider Focus

Care plans for members needing complex case management but who are unable or unwilling to actively engage will focus on the needs of the individual through communication with the PMP (if applicable), other providers and the member's natural supports system. The complex case management plan will identify the problems, barriers and issues related to the individual's health care needs and recognize why, due to the person's condition or other reasons, the member cannot actively participate. It will address goals, objectives and interventions to meeting the needs of the individual.

In contact with the member, the member may not be actively engaged in coordinating with their medical team, however, the Contractor must engage the member in learning about the member's health condition and follow the case management plan developed.

3.8.3.4 RCP Care Plans

The Contractor is required to develop a treatment plan for the RCP members, and must monitor and document whether RCP restrictions should continue.

3.8.4 Reassessments

The Contractor will develop a process for reviewing and updating the care plans with members on an as-needed basis, including upon reassessment of functional need, when the member's circumstances or needs change significantly, or at the request of the member, but no less often than annually per 42 CFR 441.301(c)(3). It is expected that members in complex case management and RCP will have care plans reviewed and updated on a schedule more often than annually.

In addition, members may move between stratified levels of care groups over time as their needs change, therefore, the Contractor shall develop a protocol for re-evaluating members periodically to determine if their present care levels are adequate. The Contractor shall also identify triggers which would immediately move the member to a more assistive level of service. The Contractor must at minimum re-screen and conduct a comprehensive health assessment for members who have been in the program for three (3) years. Additionally, any member or provider can request a level of care redetermination at any time.

The Contractor must also have a process for how members can request and, if available, be offered a different case manager according to the member's preferences and language/cultural needs.

3.9 24-hour Nurse Call Line

The Contractor shall provide nurse triage telephone services for members to receive medical advice twenty-four (24) hours-a-day/seven (7)-days-a-week from trained medical professionals. The twenty-four (24)-hour Nurse Call Line should be well publicized and designed as a resource to members to help discourage inappropriate emergency room use, particularly for members in disease management. The 24-hour Nurse Call Line may share location information of nearby urgent care clinics. The 24-hour Nurse Call Line shall have a system in place to communicate all issues with the member's PMP. In addition, as set forth in Section 3.9, the 24-Hour Nurse Call Line shall be equipped to provide advice for HIP member's seeking services from hospital emergency departments. The nurse call line shall collect data sufficient to meet program managers, member assistance and reporting needs.

3.10 Other Covered Benefits and Services

In addition to the benefits and services listed above, the Contractor shall also cover the following:

- **Evidence-based Diabetes self-management services** when the member obtains the services from IHCP self-referral providers. However, IC 27-8-14.5-6 also provides that coverage for diabetes self-management is subject to the requirements of the insurance plan (i.e., Contractor) when a member seeks diabetes self-management services from providers other than providers designated as IHCP self-referral providers. The statute also recognizes that eye care and podiatry, which may include diabetes self- management services, are self-referral services. The Contractor may direct its members to providers in the Contractor's network for diabetes self-management services. However, the Contractor shall cover diabetes self-management services if the member chooses an IHCP self-referral provider outside the Contractor's network.

- The Contractor shall provide evidence-based **prenatal care programs** targeted to avert untoward outcomes in high-risk pregnancies. The Contractor must have a comprehensive member outreach strategy to make persons aware of the benefits available to pregnant members and the importance of early and continuous prenatal care.

- The Contractor shall provide evidence-based **newborn health, postpartum care and parenting education.**

- The Contractor shall provide a comprehensive evidence-based Preventive Care Benefit. HIP is designed to facilitate access to, and emphasize the importance of, preventive care. Covered HIP benefits include "first dollar" coverage for preventive care services. Such services are not subject to the deductible and no cost-sharing applies. Members can use the preventive care benefit to cover routine preventive services such as mammograms, colorectal screenings, tobacco dependence treatment classes, etc. Each year, FSSA will identify which preventive services will be covered in the "first dollar" coverage. "Preventive care services" means care that is provided to an individual to prevent disease, diagnose disease or promote good health.

- The Contractor shall provide evidence-based Hospice Care, provided in a facility or in the home, is a covered service. Subject to the limitations and definitions set forth in Indiana Code and in the list of covered benefits. Hospice care is a special way of caring for people who are terminally ill, and for their family. This care includes

physical care and counseling. Hospice care is covered under Hospital Insurance (see also: 42 CFR § 418.3).

3.11 Carved-out Services

Some services are not included in the Contractor's capitation rates for the HIP populations and, therefore, are not the responsibility of the Contractor. These services are referred to as "carved-out" services. Carved-out services, as defined by the State, include services that are carved out of managed care program coverage, meaning that they are the financial responsibility of the State to provide to managed care members via fee-for-service (FFS) Medicaid benefits. This definition also includes services that could potentially require a managed care member to be disenrolled from a managed care plan and instead be reenrolled into traditional Medicaid to obtain the FFS benefit.

The State fiscal agent pays on a FFS basis for carved-out services rendered to the Contractor's members. However, under some circumstances, services related to the carved-out services are the responsibility of the Contractor for reimbursement.

Listed below are the carved-out services in the HIP program and the conditions under which related services are the Contractor's responsibility.

The HIP MCE Policies and Procedures Manual describes these carved-out services in greater detail.

3.11.1 Medicaid Rehabilitation Option (MRO) Services

The Contractor is not responsible for claims reimbursement for such services. However, the Contractor is responsible for ensuring care coordination, as described in Sections 3.7 and 3.8, with physical and other behavioral health services for individuals receiving MRO services. See the MRO Provider Reference Module for specific codes for MRO services.

3.11.2 1915(i) State Plan Home and Community-Based Services

The State has three (3) 1915(i) State Plan Home and Community-Based services programs: Behavioral and Primary Healthcare Coordination (BPHC), Adult Mental Health and Habilitation (AMHH) and Children's Mental Health Wraparound (CMHW). These services are carved-out of the Contractor's financial responsibility. The Contractor shall coordinate with 1915(i) services to prevent duplication and fragmentation of services. A listing of carved-out 1915(i) services is provided in the respective Provider Reference Modules. As described in Section 3.12.4, some individuals receiving BPHC will be disenrolled from the Contractor.

3.12 Excluded Services

The HIP program excludes some benefits from coverage under managed care. These benefits are available under Traditional Medicaid or other waiver programs and are therefore excluded from the programs as described below. A member who is, or will be, receiving excluded services must be disenrolled from managed care in order to be eligible for these services. Excluded services are defined by the State as services that are not covered under Indiana Medicaid (see also: 405 IAC 5-29-1).

The HIP MCE Policies and Procedures Manual describe member disenrollment in greater detail.

EXHIBIT 1B

SCOPE OF WORK – HEALTHY INDIANA PLAN

Listed below are the services excluded from the HIP program.

3.12.1 Long-Term Institutional Care

HIP members requiring long-term care in a nursing facility or Intermediate Care Facility for the Intellectually Disabled (ICF/ID) must be disenrolled from the HIP program and converted to an appropriate IHCP eligibility category. The Contractor must work with the facility to determine the type of stay, rehabilitative or custodial, upon admission and follow up every five (5) business days of confirm the type of stay. The Contractor must also contact the State eligibility unit within ten (10) business days upon confirming a custodial stay with the facility to ensure the member is transitioning to another eligibility category. Before the nursing facility can be reimbursed by IHCP for the care provided, the nursing facility must request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State must then approve the PASRR request, designate the appropriate level of care in *Core*MMIS and disenroll the member from HIP. The Contractor must coordinate care for its members that are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR, as described in the IHCP Provider Manual.

However, the Contractor may obtain services for its members in a nursing facility setting on a short-term basis, i.e., for fewer than thirty (30) calendar days. This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. The Contractor may negotiate rates for reimbursing the nursing facilities for these short-term stays. All over-the-counter, legend, and nonlegend drugs, including physician-administered drugs are not considered allowable costs and should not be included in the per diem rate. All drugs must be reimbursable through the pharmacy benefit but may be subject to prior authorization and safety edits that are no more restrictive than Fee-for-Service. The Contractor may request disenrollment of a member in these cases.

3.12.2 1915(c) Home and Community-Based Services (HCBS) Waiver

Home- and community-based waiver services are excluded from the HIP program. Similar to the situations described above, members who have been approved for these waiver services shall be disenrolled from managed care and the Contractor shall coordinate care for its members that are transitioning into a HCBS waiver program until the disenrollment from Hoosier Healthwise or HIP is effective.

3.12.3 Psychiatric Treatment in a State Hospital

HIP members receiving psychiatric treatment in a state hospital shall be disenrolled from HIP, if the anticipated stay is greater than 30 days.

3.12.4 Behavioral and Primary Healthcare Coordination (BPHC) Services

Members who become eligible for Medicaid via the BPHC Program through the State's coverage of the optional categorically needy eligibility group under 1902(a)(10)(A)(ii)(XXII) will be disenrolled from HIP. As described in Section 3.11.2, individuals eligible to receive BPHC services who are otherwise eligible for a HIP eligibility category will remain enrolled with the Contractor but the Contractor shall not be financially responsible for reimbursement of the BPHC service.

3.12.5 Psychiatric Residential Treatment Facility (PRTF) Services

Members who are admitted to a PRTF shall have their enrollment with the Contractor suspended. As part of the discharge planning process the PRTF shall evaluate the member for transition to the Medicaid fee-for-service. If Medicaid fee-for-service enrollment is not appropriate or accessible, the member will be reenrolled with the Contractor upon PRTF discharge. In these cases, the Contractor shall work with the PRTF on discharge planning.

3.13 Continuity of Care

The State is committed to providing continuity of care for members as they transition between various IHCP programs and the Contractor's enrollment. The Contractor shall have mechanisms in place to ensure the continuity of care and coordination of medically necessary health care services for its HIP members. The State emphasizes several critically important areas where the Contractor shall address continuity of care. Critical continuity of care areas include, but are not limited to:

- Transitions for members receiving HIV, Hepatitis C and/or behavioral health services, especially for those members who have received prior authorization from their previous MCE or through fee-for-service;
- A member's transition into the HIP program from traditional fee-for-service;
- A member's transition between MCEs, particularly during an inpatient stay;
- A member's transition between IHCP programs, particularly when a HIP member becomes pregnant or disabled;
- A member's transition following a medically frail determination;
- Members exiting the HIP program to receive excluded services;
- A member's transition to a new PMP;
- A member's transition to private insurance or Marketplace coverage;
- A member's transition to no coverage; and
- A member's transition between HIP benefit plans (i.e. HIP Plus, HIP Basic, and HIP State Plan).

In situations such as a member or PMP disenrollment, the Contractor shall facilitate care coordination with other MCEs or other PMPs. When receiving members from another MCE or fee-for-service, the Contractor shall honor previous authorizations for a minimum of ninety (90) calendar days from the member's date of enrollment with the Contractor. The Contractor shall establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's enrollment in their plan. For purposes of clarification, the date of member enrollment for purposes of the prior authorization time frames set forth in this section begin on the date the Contractor receives the member's fully eligible file from the State.

Additionally, when a member transitions to another source of coverage, the Contractor shall be responsible for providing the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as

disease management, case management or care management notes. This process shall be overseen by the Transition Coordination Manager.

The Contractor will be responsible for care coordination after the member has disenrolled from the Contractor whenever the member disenrollment occurs during an inpatient stay. In these cases, the Contractor will remain financially responsible for the hospital DRG payment and any outlier payments (without a capitation payment) until the member is discharged from the hospital or the member's eligibility in Medicaid terminates. The Contractor shall coordinate discharge plans with the member's new MCE.

See Section 3.7 for additional requirements regarding continuity of care for behavioral health services, and Section 12.4 for additional requirements regarding continuity of care for pregnant members. The HIP MCE Policies and Procedures Manual describes the Contractor's continuity and coordination of care responsibilities in more detail.

3.14 Out-of-Network Services

With the exception of certain self-referral services described in Section 3.2, and the requirements to allow continuity of care for pregnant women transferring to the Contractor in their third trimester described in Section 12.4, the Contractor may limit its coverage to services provided by in-network providers once the Contractor has met the network access standards set forth in Section 5.2. However, in accordance with 42 CFR 438.206(b)(4), which relates to coverage of out-of-network services, the Contractor shall authorize and pay for out-of-network care if the Contractor is unable to provide necessary covered medical services within sixty (60)-miles of the member's residence by the Contractor's provider network. In addition, the State may also require the Contractor to begin providing out-of-network care in the event the Contractor is unable to provide necessary covered medical services within the Contractor's provider network within specified timeliness standards defined by the State.

The Contractor shall authorize these out-of-network services in the timeframes established in Section 6.3.1 and shall adequately cover the services for as long as the Contractor is unable to provide the covered services in-network. The Contractor shall require out-of-network providers to coordinate with the Contractor with respect to payment. Per 42 CFR 438.206(b)(5), the cost to the member for out-of-network services shall be no greater than it would be if the services were furnished in-network.

The Contractor may require providers not contracted in the Contractor's network to obtain prior authorization from the Contractor to render any non-self-referral or non-emergent services to Contractor members. If the out-of-network provider has not obtained such prior authorization, the Contractor may deny payment to that out-of-network provider. The Contractor shall cover and reimburse for all authorized, routine care provided to its members by out-of-network providers.

Contractors shall make covered services provided by FQHCs and RHCs available to HIP members out-of-network if an FQHC or RHC is not available in the member's service area within the Contractor's network.

The Contractor may not require an out-of-network provider to acquire a Contractor-assigned provider number for reimbursement. An NPI number shall be sufficient for out-of-network provider reimbursement.

3.15 Out-of-Network Provider Reimbursement

The Contractor shall reimburse any out-of-network provider's claim for authorized services provided to HIP members. The Contractor shall reimburse any out-of-network provider's

claim for authorized services according to administrative code 405 IAC 10-9-4 (b) and State statute IC 12-15-44.5-5.

3.16 Enhanced Services

The State encourages the Contractor to cover programs that enhance the general health and well-being of its HIP members, including programs that address preventive health, risk factors or personal responsibility. These enhanced programs and services are above and beyond those covered in the HIP program. For enhanced services developed for HIP, the enhancements shall be developed to align with the overall program goals aimed at creating a commercial market experience and encouraging member participation in HIP Plus. Therefore, enhanced benefits and services shall only be offered to HIP Plus and HIP State Plan Plus members. Notwithstanding the foregoing, the Contractor may elect to provide enhanced benefits and services to HIP Basic and HIP State Plan Basic members, provided that such benefits and services are not applied against the member's POWER Account.

In addition, all enhanced services shall comply with the member incentives guidelines set forth in Section 6.2.2 and other relevant state and federal rules regarding inducements All enhanced services offered by the Contractor shall be pre-approved by FSSA prior to initiating such services.

Enhanced services may include, but are not limited to, such items as:

- Enhanced transportation arrangements (i.e., transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.);
- Enhanced tobacco treatment dependence services;
- Disease management programs or incentives beyond those required by the State;
- Healthy lifestyles incentives;
- Group visits with nurse educators and other patients;
- Medical equipment or devices not already covered under the HIP program to assist in prevention, wellness, or management of chronic conditions; and
- Cost effective supplemental services which can provide services in a less restrictive setting.

While member enhancements and incentives can be powerful tools, these programs need to be thoughtfully designed to ensure there are no unintended consequences, for example increasing disparities or limiting access. To this end, the State has developed guidance to encourage the Contractor to consider the following set of guiding principles in their design and implementation as building blocks of member enhancements and incentives:

- Culturally sensitive – Ensuring cultural sensitivity is necessary to provide successful outcomes, as cultural norms differ and may need to be incentivized differently;
- Unbiased – Creating unbiased enhancements and incentives are necessary to comply with federal laws. Incentives must not leave out any groups on the basis of ethnicity, education, race, social class, ability, etc.);

- Possess equity – Equality is not enough when providing enhanced services and incentives, rather maintaining equity should also be considered (equality would be providing a pair of size 10 shoes to everyone; equity is providing a pair of the correct size shoes to everyone);

- Communicated appropriately in a timely manner – Incorporate the most appropriate and farthest reaching vehicle to communicate the enhanced benefit and incentive so as not to exclude members (e.g., lack of literacy and technology should be considered). Appropriate messaging should capture high quality outcomes;

- Be relevant – If barriers exist that prevent members from using the enhanced service and incentive, the incentive will not hold much value (e.g., a member is given a gym membership as an incentive but does not have the transportation to get to the gym).

It is important to note the process of designing member enhanced services and incentives is complex and the Contractor will need to consider underlying disparities and social determinants of health including community needs, and local planning efforts. Member enhanced services and incentives must not reinforce disparities or perpetuate inequality within or between communities, particularly in terms of how disparate subpopulations access wellness services and support.

3.17 Member Cost-Sharing Limits

Federal regulation 42 CFR 447.56 places aggregate limits on cost-sharing and prohibit total member cost-sharing per family—including POWER Account contributions, premiums, co-payments and co-insurance—from exceeding five percent (5%) of the family's income, as determined by the State, in a monthly or quarterly period.

To ensure a family's total cost-sharing does not exceed five percent (5%) of the family's income on a quarterly basis, the Contractor shall accept family income data from the State's fiscal agent and track the POWER Account contributions, premiums, tobacco surcharge, co-payments, member debt collected and/or other cost-sharing information available to the Contractor against the total family income data provided by the State. Any service not specifically listed as a covered benefit in the applicable HIP alternative benefit plan may not be applied against the member's five percent (5%) contribution calculation. The time period for tracking data shall be defined by the State.

When a family's total cost-sharing expenditures come close to exceeding five percent (5%) of the family's income in the quarterly period, the Contractor shall be required to notify the State. The Contractor shall also coordinate with the State to notify providers and the family that additional cost-sharing during the period is reduced or waived. Members with tobacco surcharge will still be responsible for the $1.50 POWER Account contribution once they meet the five percent (5%) limit.

In monitoring the quarterly five percent (5%) member cost-sharing limit, the Contractor shall comply with all policies and procedures set forth in this section and the HIP MCE Policies and Procedures Manual.

3.18 Opioid Treatment Program (OTP)

The Contractor shall provide coverage for the daily Opioid Treatment Program (OTP). A daily opioid treatment program includes administration and coverage of an FDA-approved opioid agonist or antagonist medication-assisted treatment (MAT) medication, routine drug testing, group therapy, individual therapy, pharmacological management, follow-up

examinations, and one evaluation and management office visit every 90 days for the management of patient activities identified in the individualized treatment plan that assist in patient goal attainment, including referrals to other service providers and linking patients to recovery support groups. OTP coverage will include those members as defined by FSSA and approved by CMS. The MCE will be responsible for OTP services provided by the provider type Addictions Provider and the provider specialty OTP as defined in the IHCP Provider Enrollment Type and Specialty Matrix.

Eligible members include:

- Members 18 years and older who have become addicted at least one year prior to admission and are placed in the Opioid Treatment Services (OTS) Level of Care according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

- Members under 18 years of age and have had two documented unsuccessful attempts at short-term withdrawal management or drug free treatment within a 12-month period.

- All members released from penal institution (within six months of release).

- Pregnant members.

- Previously treated members (up to two years after discharge).

3.19 Dental Services

Dental services are a covered benefit under the HIP program per Exhibit 3.B Program Description and Covered Benefits that the Contractor is responsible for managing and reimbursing. There are two distinct benefits under HIP Basic and HIP Plus. The Contractor will develop a comprehensive oral health strategy, in consultation with dental providers, that ensures appropriate utilization of this benefit by members consistent with dental standards of care.

3.20 Non-Emergency Medical Transportation Services

Non-emergency medical transportation (NEMT) services are a covered benefit under the HIP program for HIP Maternity and HIP State Plan members per Exhibit 3.B Program Description and Covered Benefits that the Contractor is responsible for managing and reimbursing. NEMT services are intended for members who have no other means of transportation available to them.

Under the Consolidated Appropriations Act, 2021, Division CC, Title II, Section 209 the Contractor must provide for a mechanism, which may include attestation, that ensures any provider (including a transportation network company) or individual driver of non-emergency transportation to medically necessary services receiving payments under such plan (but excluding any public transit authority), meets specified minimum requirements. These minimum requirements under the State Plan must include that:

- Each provider and individual driver are not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Social Security Act) and are not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

- Each such individual driver has a valid driver's license;

- Each such provider has in place a process to address any violation of a State drug law; and

- Each such provider has in place a process to disclose to the State Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

3.21 Residential Substance Use Disorder (SUD) Services

Short-term low-intensity and high intensity residential treatment for opioid use disorder (OUD) and other substance use disorder (SUD) in settings of all sizes, including facilities that qualify as institutes of mental disease (IMDs) are a covered benefit under the HIP program per Exhibit 3.B Program Description and Covered Benefits that the Contractor is responsible for managing and reimbursing.

Prior authorization (PA) is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria:

- ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services
- ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

When residential services are determined medically necessary for a member, the Contractor will approve a minimum of fourteen (14) days for residential treatment, unless the facility requests fewer than fourteen (14) days. If a facility determines that a member requires more time than the initial fourteen (14) days, the facility should submit a PA update request showing that the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity.

4.0 Member Services

4.1 Marketing and Outreach

Marketing efforts shall be targeted to the general community in the Contractor's entire service area. In accordance with 42 CFR 438.104, and the requirements outlined in Section 4.5, the Contractor must obtain State approval for all marketing materials at least thirty (30) calendar days prior to distribution. All marketing materials must be distributed to the Contractor's entire service area and shall comply with the information requirements delineated at 42 CFR 438.10. Such materials shall be in a manner and format that is easily understood and meet the general communication material requirements discussed further in Section 4.0. Marketing materials should include the requirements and benefits of the Contractor's health plan, as well as the Contractor's provider network.

The Contractor may market via digital, mail, and mass media advertising (e.g., radio, television and billboards) and community-oriented marketing directed at potential members. Community oriented marketing such as participation in community health fairs is encouraged. Tokens or gifts of nominal value may be distributed at such events to potential members, so long as the Contractor acts in compliance with all marketing provisions provided for in 42 CFR 438.104, and other federal and state regulations and guidance regarding inducements in the Medicaid program. The Contractor shall conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. The Contractor shall provide information to potential eligible individuals who live in medically underserved rural areas of the State.

Any outreach and marketing activities (written and oral) shall be presented and conducted in an easily understood manner and format, at a fifth-grade reading level.

The Contractor may not seek to influence enrollment in conjunction with the sale or offering of any private insurance and may not directly, or indirectly engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. Cold-call marketing is defined at 42 CFR 438.104 and includes any unsolicited personal contact by the Contractor with a potential Medicaid member. The Contractor shall ensure marketing materials are accurate and do not mislead, confuse or defraud members or the State. Statements considered inaccurate, false, or misleading include, but are not limited to, any assertion or written or oral statement that:

- The member or potential member must enroll in the Contractor's health plan to obtain benefits or to avoid losing benefits;
- The Contractor is endorsed by CMS, the Federal or state government or a similar entity; or
- The Contractor's health plan is the only opportunity to obtain benefits under the Healthy Indiana Plan program.

The Contractor cannot entice a potential member to join its health plan by offering any other type of insurance as a bonus for enrollment, and the Contractor shall ensure that a potential member can make his/her own decision as to whether or not to enroll. Marketing materials and plans shall be designed to reach a distribution of potential members across age and gender categories. The Contractor must conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. The Contractor must provide information to potentially eligible individuals who live in medically underserved rural areas of the State. Potential members may not be discriminated against on the basis of health status or need for health care services, or on any other basis inconsistent with state or federal law, including Section 1557 of the Affordable Care Act / 45 CFR 92.1.

The Contractor may distribute or mail an informational brochure or flyer to potential members and/or provide (at its own cost, including any costs related to mailing) such brochures or flyers to the State for distribution to individuals at the time of application.

The Contractor shall submit product naming and associated domains to FSSA for review and approval to minimize confusion for members and providers.

4.2 Member Enrollment and Contractor Selection

Healthy Indiana Plan applicants have an opportunity to select an MCE on their application. MCEs are expected to conduct marketing and outreach efforts to raise awareness of both the program and their product. The Enrollment Broker is available to assist members in choosing an MCE. Applicants who do not select an MCE on their application will be auto-assigned to an MCE according to the State's auto-assignment methodology. The State reserves the right to amend the auto-assignment logic and may incorporate HEDIS or other quality indicators into the auto-assignment logic at a future date. Default auto-assignment will not be available to any MCE who does not successfully complete readiness review. Members that lose Medicaid eligibility for the HIP program for a period of three (3) months or less shall be automatically reenrolled with the Contractor, 42 CFR 438.56(g).

Members will have the opportunity to change their MCE at the following intervals:

1. At least once every 12 months thereafter

2. At any time using the just cause process (defined below)

3. A beneficiary may change HIP MCEs without cause if the change is requested prior to: (i) the date the beneficiary pays their initial POWER account contribution or fast track POWER account prepayment, or (ii) has defaulted into HIP Basic for non-payment of fast-track prepayment or POWER Account contribution whichever comes first. Disenrollment without cause for the reasons identified in 42 CFR 438.56(c)(2)(ii), (iii) and (iv) will also be permitted.

4. Each November 1- December 15 during the annual selection period, beneficiaries will have the opportunity to select their MCE for the coming benefit period. Prior to the open selection period, beneficiaries will be reminded of their ability to select a new MCE. Beneficiaries may make a selection by contacting the enrollment broker.

Any Medicaid member may change their MCE for Just Cause. The "for cause" reasons are described in 42 CFR 438.56(d)(2). Determination as to whether a member has met one of these reasons is solely the determination of the Enrollment Broker and FSSA. The reasons include, but not limited to, the following:

- Receiving poor quality of care;
- Failure to provide covered services;
- Failure of the Contractor to comply with established standards of medical care administration;
- Lack of access to providers experienced in dealing with the member's health care needs;
- Significant language or cultural barriers;
- Corrective action levied against the Contractor by the office;
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the Contractor's contract with the State;
- A service is not covered by the Contractor for moral or religious objections, as described in Section 6.3.2;
- Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE. The enrollee would have to change their residential, institutional, or employment supports provider based on that provider's

change in status from an in-network to an out-of-network provider and, as a result, would experience a disruption in their residence or employment; or

- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

4.2.1 Enrollment and Practice Discrimination

Per 42 CFR 438.3(d), the Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction. The Contractor shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll. Additionally, the Contractor shall not discriminate against individuals eligible to enroll on the basis of race, color, age, national origin, sex, sexual orientation, gender identity, genetic information, income status, HIP membership, or disability and will not use any policy or practice that has the effect of discriminating in such manner.

Examples of prohibited practices include, but are not limited to, the following:

1. Denying or not providing a member any covered service or access to an available facility,

2. Providing to a member any medically necessary covered service which is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary,

3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in their enjoyment of any advantage or privilege enjoyed by others receiving any covered service, and

4. Assigning times or places for the provision of services on the basis of the race, color, age, national origin, sexual orientation, gender identity, genetic information, income status, HIP membership, or disability of the members to be served.

The Contractor shall assure members their rights as specified in 42 CFR 438.100.

The Contractor shall ensure members and individuals with disabilities are accommodated to actively participate in the provision of services and have physical access to facilities, procedures and exams. For example, the Contractor shall provide appropriate auxiliary aids and services to individuals with impaired sensory, manual, or speaking skills. The Contractor shall provide accommodations to members and individuals with disabilities at no cost to afford such individuals an equal opportunity to benefit from the covered services.

If the Contractor knowingly executes a subcontract with a provider with the intent of allowing or permitting the provider to implement barriers to care, (i.e. the terms of the subcontract act to discourage the full utilization of services by some members) the Contractor is in default of its Contract.

If the Contractor identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its providers, the Contractor shall promptly

intervene and require a corrective action plan from the provider. Failure to take prompt corrective measures may place the Contractor in default of its Contract.

Contractor shall also adhere to Section 1557 of the Affordable Care Act / 45 CFR 92.1.

Member enrollment with the Contractor will be for the full 12-month calendar year benefit period once the member makes an initial POWER Account contribution. Members will have the opportunity to select a new MCE every year between November 1st to December 15th as part of the open enrollment period.

4.2.2 Enrollment Packet

Within five (5) calendar days of a new member's full enrollment with the Contractor in accordance with Section 13.6, the Contractor shall send the new member a Welcome Packet based on the State's model enrollee handbook. All information in the Enrollment Packet shall meet the general information requirements set forth in this section and shall be submitted for State review and approval prior to distribution in accordance with Section 4.5. The Welcome Packet shall include, but not be limited to, a new member letter, explanation of where to find information about the Contractor's provider network, where to locate the member handbook including a summary of items found in the member handbook as described in Section 4.4.3, and the member's ID card. The Contractor shall be responsible for issuing member ID cards to all of its new HIP members. Furthermore, if a member loses their card, the Contractor will be responsible for printing new member ID cards for their members. Refer to the HIP MCE Policies and Procedures Manual for specific information regarding HIP member ID card requirements.

The Welcome Packet shall include information on the HIP member ID card. The HIP member ID card shall include the member's MID number, as well as the applicability of cost-sharing. Specifically, at minimum, the card shall indicate emergency services co-payments and other co- payments may apply, and direct the provider to call the Contractor for specific amounts.

The Welcome Packet shall include information about selecting a PMP, completing a health needs screening and any unique features of the Contractor. For example, if the Contractor incentivizes members to complete a health needs screening, a description of the member incentive should be included in the Welcome Packet.

The HIP Welcome Packet shall also include educational materials about unique features of the program, including, but not limited to:

- The POWER Account;
- Member required cost sharing;
- POWER Account rollover, including the recommended preventive care services for the member's benefit year; and
- General information regarding the importance of timely completion of the comprehensive health assessment for members initially identified as potentially medically frail.

4.2.3 PMP Selection

The Contractor shall assure that each member has a PMP who is responsible for coordinating the services accessed by the member and providing an ongoing source of primary care appropriate to the member's needs in accordance with 42 CFR 438.208(b)(1). Following a member's enrollment, the Contractor shall assist the member in choosing a PMP and provide information to the member on how to contact their designated PMP or entity. Unless the member elects otherwise, the member shall be assigned to a PMP within thirty (30) miles of the member's residence.

If a member fails to initially select a PMP, the Contractor shall assign the member to a PMP within thirty (30) calendar days of the member's enrollment. The member shall be assigned to a PMP within thirty (30) miles of the member's residence, and the Contractor should consider any prior provider relationships when making the assignment. The Contractor's PMP auto assignment logic is to be submitted with their proposal. FSSA shall approve the Contractor's PMP auto-assignment process prior to implementation, and the process shall comply with any guidelines set forth by FSSA. See the HIP MCE Policies and Procedures Manual for further detail. The Contractor shall notify the member in writing of the auto- assigned provider, the member's right to change PMP, as well as the process by which the member may change PMP.

The Contractor shall have written policies and procedures for allowing members to select a new PMP, including PMP auto-assignment, and provide information on options for selecting a new PMP when it has been determined that a PMP is non-compliant with provider standards (i.e., quality of care) and is terminated from the MCE, or when a PMP change is ordered as part of the resolution to a grievance proceeding. The MCE shall allow the member to select another PMP. The notice shall include information on options for selecting a new PMP. The Contractor's written policies and procedures for PMP selection must be approved by FSSA.

Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians, gynecologists and endocrinologists (if primarily engaged in internal medicine).

4.2.4 Provider Network Information

The Enrollment Packet shall include information on where to find information about the Contractor's provider network. Additionally, the Contractor shall include a current provider directory and/or information on how to find a network provider near the member's residence on-line and via the Member Helpline. In accordance with 42 CFR 438.10(h), the provider directory must include the following information:

- Primary care physicians, specialists and hospitals;
- Name, location and telephone number of providers;
- Identification of non-English language spoken by providers;
- Provider web sites, if applicable;
- If the provider has accommodations for people with physical disabilities;
- Pharmacies and behavioral health providers;
- Contact information for all brokers contracted with the MCE; and
- Identification of providers that are not accepting new patients.

A printed copy of the provider directory must also be available to members and FSSA upon request. The Contractor must include the aforementioned provider network

information, by county, on its member website. The information must be updated, at minimum, every two (2) weeks. Network provider information must be available to print from a remote user location.

4.2.5 Children with Special Health Care Needs

The Contractor shall have plans for provision of care for the special needs populations and for provision of medically necessary, specialty care through direct access to specialists.

The Contractor shall address any special health care needs for HIP members ages 19 and up to their 21st birthday.

The health screening tool will assign children to one of the Living with Illness Measures (LWIM) screener health domains based on the National Committee on Quality Assurance study design. The scoring for the LWIM screener identifies a child as potentially having a special health care need if the screening identifies needs in one or more of seven (7) different health domains:

- Functional limitations only
- Dependency on devices only
- Service use or need only
- Functional limitations and a dependency on devices
- Functional limitations and a service use or need
- Dependency on devices and a service use or need
- Functional limitations, a dependency on devices and a service use or need

In accordance with 42 CFR 438.208(c)(2), which specifies allowable staff, the Contractor shall have a *health care professional* assess the member through a detailed health assessment if the health screening identifies the member as potentially having a special health care need. When the further assessment confirms the special health care need, the member shall be placed in care management. The Contractor shall offer continued coordinated care services to any special health care needs members transferring into the Contractor's membership from another MCE. For example, Contractor activities supporting special health care needs populations shall include, but are not limited to:

- Conducting the initial screening and more detailed health assessment to identify members between 19 and 21 years of age who may have special needs;

- Scoring the initial screening and more detailed health assessment results;

- Distributing findings from the health assessment to the member's PMP, FSSA and other appropriate parties in accordance with state and federal confidentiality regulations;

- Coordinating care through a Special Needs Unit or comparable program services in accordance with the member's care plan;

- Analyzing, tracking and reporting to FSSA the issues related to children with special health care needs, including grievances and appeals data; and

- Participating in clinical studies of special health care needs as directed by the

State.

4.2.6 Member Disenrollment from MCE

In accordance with 42 CFR 438.56(b)(2), the Contractor may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs, adverse change in a member's health care status, diminished mental capacity, or because of uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the member or other members) . A member's health care utilization patterns may not serve as the basis for disenrollment from the Contractor.

In accordance with 42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); and 42 CFR 438.56(c)(2)(i)-(iii), members have the right to disenroll from the Contractor:

- For cause, at any time.
- Without cause within ninety (90) days after initial enrollment or during the ninety (90) days following notification of enrollment, whichever is later.
- Without cause at least once every twelve (12) months.
- Without cause when a Contractor repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438 and section 1932(e)(2)(B)(ii) of the Social Security Act.
- Without cause upon reenrollment if a temporary loss of enrollment has caused the enrollee to miss the annual disenrollment period.

In accordance with 42 CFR 438.56(d)(2)(i)-(v), members may request disenrollment if the:

- Member moves out of the service area.
- Contractor does not cover the service the enrollee seeks, because of moral or religious objections.
- Member needs related services to be performed at the same time and not all related services are available within the provider network. The member's provider must determine that receiving the services separate would subject the member to unnecessary risk,
- Contractor's provider status changes from in-network to out-of-network causes the member to have to change their residential, institutional, or employment supports provider, and, as a result, the member would experience a disruption in their residence or employment.
- Member experiences poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the member's care needs.

See additional standards and procedures allowing for change of Contractor in the Member Handbook section.

The Contractor shall notify FSSA in the manner outlined in the HIP MCE Policies and Procedures Manual, within thirty (30) calendar days of the date it becomes aware of the death of one of its members, giving the member's full name, address, Social Security Number, member identification number and date of death. The Contractor

will have no authority to pursue recovery against the estate of a deceased Medicaid member.

Additional information about the member disenrollment process is provided in Exhibit 4.A and the HIP MCE Policies and Procedures Manual.

Members must file a grievance with their MCE before a determination will be made upon their just cause request for disenrollment and the Contractor must ensure it reviews the grievance in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment or the Contractor refers the request to the broker per 42 CFR 438.56(d)(5)(ii), 42 CFR 438.56(e)(1) and 42 CFR 438.228(a).

Per 42 CFR 438.56(e)(2), if a disenrollment determination is not made within the specified timeframes (i.e., the first day of the second month following the month in which the enrollee requests disenrollment or the Contractor refers the request to the broker), the disenrollment is considered approved for the effective date that would have been established had the determination been made in the specified timeframe.

4.3 Member-Contractor Communications

The Contractor will be responsible for developing and maintaining member education programs designed to provide members with clear, concise and accurate information about the Contractor's program, the Contractor's network and the Healthy Indiana Plan program. This should be delivered in a multimedia format that does not exclusively consist of telephonic and written correspondence outreach. The State encourages the Contractor to incorporate community advocates, community health workers, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs.

The Contractor shall maintain strategies for communicating with members. Contractor communication strategies must meet the requirements of this section and provide innovative approaches to ensure member understanding of the Healthy Indiana Plan program. The Contractor shall also develop approaches to increase member awareness of their health condition(s), treatment protocols and the importance of preventive care.

4.3.1 Member Services Helpline and 24-Hour Nurse Line

The Contractor shall maintain a statewide toll-free telephone helpline staffed with trained personnel knowledgeable about the HIP program equipped to handle a variety of member inquiries, including the ability to address member questions, concerns, complaints and requests for PMP changes. The same helpline shall be available to HIP members, so that members may call one number to answer all the family's questions. Member helpline staff shall be equipped to provide customer service to individuals assigned to the Contractor's plan who have not yet made their first POWER Account contribution. The helpline staff must be based in Indiana and take at a minimum seventy percent (70%) of the Indiana Medicaid calls, except when emergency rollover is required. The State must be notified if such an emergency is taking place. A minimum of fifty percent (50%) of helpline staff must be employees of the prime Contractor.

The Contractor shall staff the member services helpline to provide sufficient "live voice" access to its members during, at a minimum, a twelve (12)-hour business day, from 8 a.m. to 8 p.m. Eastern, Monday through Friday. The call center shall open 60 days prior to the Contractor's go live date, with State approval. The Contractor shall

provide a voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day.

The member helpline may be closed on the following holidays:

- New Year's Day;
- Martin Luther King, Jr. Day
- Memorial Day;
- Independence Day (July 4th);
- Labor Day;
- Thanksgiving; and
- Christmas.

The Contractor may request that additional days, such as the day after Thanksgiving, be authorized for limited staff attendance. This request shall be submitted to FSSA at least thirty (30) calendar days in advance of the date being requested for limited staff attendance and shall be approved by FSSA.

For all days with a closure, early closing or limited staff attendance, members shall have access to the 24-Hour Nurse Call Line as appropriate. Call center closures, limited staffing or early closures shall not burden a member's access to care.

The member services helpline shall offer language translation services for members whose primary language is not English and shall offer automated telephone menu options in English and Spanish. A member services messaging option shall be available after business hours in English and Spanish. The Contractor shall provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members. There must also be at least 1 fluent Burmese speaker and 1 fluent Spanish speaker physically present (i.e., not via a language translation line) to answer member calls during all "live" operating hours.

Member services helpline staff shall be trained in the HIP program to ensure that member questions and concerns are resolved as expeditiously as possible. The Contractor shall have the ability to warm transfer members to outside entities including the Enrollment Broker, the Division of Family Resources (DFR) and provider offices. Additionally, the Contractor shall ensure the warm transfer of calls for members that require attention from a Contractor care manager. The Contractor shall ensure the care manager has access to all information necessary to resolve the member's issues. Any messages left with care managers must be returned by the next business day.

The Contractor shall maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours. The Contractor shall monitor its member services helpline service and report its telephone service level performance to FSSA in the timeframes and specifications described in the HIP MCE Reporting Manuals.

The Contractor's member services helpline staff shall be prepared to efficiently respond to member concerns or issues including, but not limited to the following:

- Access to health care services;
- Identification or explanation of covered services;
- Special health care needs;
- Procedures for submitting a member grievance or appeal;

- Potential fraud or abuse;
- Changing PMPs;
- POWER Accounts and POWER Account balances;
- HIP POWER Account contributions, including initial fast track prepayments;
- Transfers between HIP benefit plans;
- Incentive programs;
- Disease management services, care management and complex case management services;
- Recommended age and sex appropriate preventive services (HIP only);
- Transfers between Hoosier Healthwise and HIP coverage;
- Employer and other third-party HIP POWER Account contributions;
- Balance billing issues;
- Referrals to local services or community-based organizations for assistance; and
- Health crises, including but not limited to suicidal callers.

Upon a member's enrollment with the Contractor, the Contractor shall inform the member about the member services helpline. The Contractor should encourage its members to call the member services helpline as the first resource for answers to questions or concerns about HIP, PMP issues, benefits, Contractor policies, etc.

The Contractor shall maintain sufficient equipment and staff to ensure the following:

- For any calendar month, at least ninety-seven percent (97%) of all phone calls to the helpline must reach the call center menu within thirty (30) seconds.

- For any calendar month, at least eighty-five percent (85%) of all phone calls to an approved automated helpline must be answered by a helpline representative within thirty (30) seconds after the call has been routed through the call center menu. Answered means that the call is picked up by a qualified helpline staff person.

- For any calendar month, at least ninety-five percent (95%) of all phone calls to an approved automated helpline must be answered by a helpline representative within sixty (60) seconds after the call has been routed through the call center menu. Answered means that the call is picked up by a qualified helpline staff person.

- If the Contractor does not maintain an approved automated call distribution system, for any calendar month, at least ninety-five percent (95%) of all phone calls to the helpline must be answered within thirty (30) seconds.

- Hold time does not exceed one (1) minute in any instance, or thirty (30) seconds, on average.

- For any calendar month, the lost call (abandonment rate) associated with the helpline does not exceed five percent (5%).

The Contractor shall provide a backup solution for phone service in the event of a power failure or outage or other interruption in service. Such plan shall include, at minimum, the following:

- A notification plan that ensures FSSA is notified when the Contractor's phone system is inoperative or a back-up system is being utilized; and

- Manual back-up procedure to allow requests to continue being processed if the system is down.

In addition to the member services helpline which is staffed during regular business hours, the Contractor shall operate a toll-free twenty-four (24) hour nurse call line. The Contractor shall provide nurse triage telephone services for members to receive medical advice twenty-four (24) hours-a-day/seven (7)-days-a-week from trained medical professionals. The twenty-four (24) hour nurse call line should be well publicized and designed as a resource to members to help discourage inappropriate Emergency room use. The twenty-four (24) hour nurse call line must have a system in place to communicate all issues with the member's providers. In addition, as set forth in Section 4.3.1, the 24-Hour Nurse Call Line must be equipped to provide advice and copayment waivers for Healthy Indiana Plan members seeking services from hospital Emergency departments.

4.3.2 Electronic Communications

The Contractor shall provide an opportunity for members to submit questions or concerns electronically, via e-mail and through the member website. If a member e-mail address is required to submit questions or concerns electronically to the Contractor, the Contractor shall help the member establish a free e-mail account.

The Contractor shall respond to questions and concerns submitted by members electronically within twenty-four (24) hours. If the Contractor is unable to answer or resolve the member's question or concern within twenty-four (24) hours, the Contractor shall notify the member that additional time will be required and identify when a response will be provided. A final response shall be provided within three (3) business days.

The Contractor shall maintain the capability to report on e-mail communications received and responded to, such as total volume and response times. The Contractor shall report required information to the State on electronic communications in accordance with the requirements outlined in the Reporting Manual.

The Contractor shall collect information on member's preferred mode of receipt of Contractor-generated communications and send materials in the selected format. Options shall include the ability to receive paper communications via mail or electronic communications through email or a secure web portal when confidential information is to be transmitted. When a member notifies the Contractor of selection to receive communications electronically, that choice shall be confirmed through regular mail with instructions on how to change the selection if desired. Additionally, emails shall be sent to members alerting them anytime an electronic notice is posted to the portal; no confidential information shall be included in emails. In the event such a notification email is returned as undeliverable, the Contractor shall send the notice by regular mail within three (3) business days of the failed email. When applicable, the Contractor shall comply with a member's preferred mode of communication.

If the member elects to receive electronic communications, electronic communication shall not be used in lieu of any assistance planning requirements required by the HIP MCE Policies and Procedures Manual.

4.4 Member Information, Education and Outreach

The Contractor shall provide the information listed under this section within a reasonable

timeframe, following the notification from the State fiscal agent of the member's enrollment in the Contractor. This information shall be included in the member handbook.

All correspondence between the Contractor and either pending HIP applicants or conditionally eligible HIP members shall provide notice that the individual has the right to select another MCE before the first payment is made or enrollment is otherwise finalized in accordance with Section

13.6. The notice shall be prominently displayed on the first page and include contact information for the Enrollment Broker available to assist with MCE selection and transfer.

The Contractor shall notify all members of their right to request and obtain information in accordance with 42 CFR 438.10. In addition to providing the specific information required at 42 CFR 438.10(f) upon enrollment in the Welcome Packet as described in Section 4.2.2, the Contractor shall notify members at least once a year of their right to request and obtain this information. Individualized notice shall be given to each member of any significant change in this information at least thirty (30) days before the intended effective date of the change. Significant change is defined as any change that may impact member accessibility to the Contractor's services and benefits.

The Contractor shall comply with the information requirements at 42 CFR 438.10. All enrollment notices, informational and instructional materials must be provided in a manner and format that is easily understood. This means written materials shall not exceed a fifth-grade reading level and be in plain language. All written materials for members or potential members shall be in a font size no smaller than 12-point.

In accordance with 42 CFR 438.10(e), the State must provide potential members with general information about the basic features of managed care and information specific to each MCE operating in the potential member's service area. At minimum, this information will include factors such as MCE service area; benefits covered; network provider information; information about the potential enrollee's/member's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee/member based on their specific circumstance; which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program (for mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the member must also be specified); any cost-sharing that will be imposed by the Contractor consistent with those set forth in the State plan; and the Contractor's responsibilities for coordination of member care.

The State shall provide information on HIP MCEs in a comparative chart-like format. Once available, the State also intends to include Contractor quality and performance indicators on materials distributed to facilitate MCE selection. The State reserves the right to develop a rating system advertising Contractor performance on areas such as consumer satisfaction, network access and quality of care and services. To facilitate State development of these materials, the Contractor must comply with State, or its designee, requests for information needed to develop informational materials for potential members.

The Contractor shall make written information available in the language requested by the member. See Section 4.4.1. At the time of enrollment with the Contractor, the State shall provide the primary language of each member. The Contractor shall utilize this information to ensure communication materials are distributed in the appropriate language. In addition, the Contractor shall identify additional languages that are prevalent among the Contractor's membership. For purposes of this requirement, prevalent language is defined as any language spoken by at least three percent (3%) of the general population in the

Contractor's service area. Written information shall be readily provided to members in any such prevalent languages identified by the Contractor. Other non-prevalent languages shall be provided to the member following the requirements outlined in Section 4.4.1.

The Contractor shall ensure that for significant publications and communications taglines (short statements written in non-English languages to alert individuals with limited English proficiency to the availability of language assistance services, free of charge, and how the services can be obtained) must be included in the State's top fifteen (15) languages spoken by limited English proficient populations, and for small-size significant publications and significant communications a tagline must be included in the State's top two languages spoken by limited English proficient populations. The Contractor will provide auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in the program.

Pursuant to the Americans with Disabilities Act of 1990 (ADA) / 42 USC §12101 et. seq., all communications with members must be consistent with the ADA's prohibition on unnecessary inquiries into the existence of a disability. Contractor shall have information available in alternative formats and through the provision of auxiliary aids and services for the Contractor's health programs and activities, in an appropriate manner that takes into consideration the member's needs, including those who have visual impairment or limited reading proficiency, and at no cost to the member.

As required by 42 CFR 438.10(d)(3), the Contractor shall take into consideration the special needs of the member or potential enrollee with disabilities or limited English proficiency, and make auxiliary aids available upon request, at no cost. Additionally, per this regulation, the Contractor shall ensure that written materials that are critical to obtaining services also include taglines in the State's top 15 prevalent non-English languages and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. For other significant publications and significant communications, a tagline must be included in the State's top two languages spoken by limited English proficient populations.

The Contractor shall distribute member materials as required by this Contract. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters and identification cards at a minimum. The Contractor may distribute additional materials and information, other than those required to members in order to promote health and/or educate enrollees provided the materials are State approved. Materials, to the extent possible, shall be in plain language including the Member Handbook.

4.4.1 Additional Information Available Upon Request

The Contractor shall have written policies guaranteeing to provide all other information to members as required by CMS, including but not limited to the following information to any enrollee who requests it.

The Contractor shall inform members that information is available upon request in alternative formats and how to obtain them. OMPP defines alternative formats as braille, large font letters, audio recordings, languages other than English and verbal explanation of written materials. When a member has requested materials in a preferred alternative format, this shall be documented in the member's record. The Contractor shall supply future materials in the requested and preferred format to the member. The Contractor may review with the member and document the specific

material type the member wishes to receive in a specific format versus other formats. For example, a member may wish to receive certain materials in braille and other materials in audio recordings.

Unless a member specifically states their alternative format request is a one-time request, the Contractor shall consider the request an ongoing request and supply all future materials in the preferred format to the member.

For first-time or one-time requests from a member, the Contractor shall mail the alternative version of the document in no more than seven (7) business days from the date of the request. If, for example, the member received a wellness visit reminder flyer and called the Contractor to ask for the flyer to be sent in braille, the Contractor shall take no more than seven (7) business days to mail the braille version from the date of the member request call.

For first-time or one-time requests from a member, when the mailing is governed by NCQA or statutory requirements, the Contract shall have two (2) additional days from the NCQA or statutory timeframe to mail the document if no mailing has yet been sent to the member.

For first-time or one-time requests from a member, when the mailing is governed by NCQA or statutory requirements and the statutory notice has already been fulfilled with a regular printed letter, the Contractor shall mail the alternate version of the document in no more than seven (7) business days from the date of the request.

For existing on-going alternate format requests, the Contractor shall have two (2) additional business days from when the document would normally be required to be mailed, to mail the document in the alternate format. If, for example, a member had previously requested materials in braille, and an ID card would be sent to the member in five (5) business days, the timeline would be seven (7) business days for the braille version. The additional two (2) days applies for Contract requirements (such as ID cards) and additional mailings at the will of the Contractor, such as a wellness visit reminder postcard.

For existing on-going alternate format requests which must comply with NCQA or State law requirement, such as utilization management letters, the Contractor shall mail the documents in the alternate format within the statutory or NCQA required timeline.

As required by 42 CFR 438.10(c)(6), if the Contractor chooses to provide any required information electronically to members:

- The information must be in a format that is readily accessible.
- The information must be placed in a location on the Contractor's website that is prominent and readily accessible.
- The information must be provided in an electronic form which can be electronically retained and printed.
- The information must be consistent with content and language requirements.
- The Contractor must notify the member that the information is available in paper form without charge upon request.

- The Contractor must provide, upon request, information in paper form within five (5) business days.

The Contractor shall provide notification to FSSA, to the Enrollment Broker and to its members of any covered services that the Contractor or any of its sub-contractors or networks do not cover, or discontinues coverage of, on the basis of moral or religious grounds and guidelines for how and where to obtain those services, in accordance with 42 CFR 438.102 which relates to provider-enrollee communications. This information shall be relayed to the member before and during enrollment and within ninety (90) calendar days after adopting the policy with respect to any particular service. Refer to Section 6.3.2 for additional information.

The Contractor shall inform the members that, upon the member's request, the Contractor will provide information on the structure and operation of the Contractor and, in accordance with 42 CFR 438.10(f)(3), will provide information on the Contractor's provider incentive plans.

Grievance, appeal and fair hearing procedures and timeframes shall be provided to members in accordance with 42 CFR 438.10(g)(2)(xi), which requires specific information be provided to enrollees. Please see Section 4.9 for further information about grievance, appeal and fair hearing procedures, as well as the kind of information that the Contractor shall provide to members.

The Contractor shall be responsible for developing and maintaining member education programs designed to provide the members with clear, concise and accurate information about the Contractor's program, and the Contractor's network. The State encourages the Contractor to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the Contractor to develop community partnerships with these types of organizations, in particular with school-based health centers, community mental health centers, WIC clinics, county health departments and prenatal clinics to promote health and wellness within its membership.

As required by 42 CFR 438.10(f)(1), the Contractor is required to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis going back twelve (12) months. Such notice must be provided to members at least thirty (30) calendar days prior to the effective date of the termination. However, if the practice or practitioner notifies the Contractor less than thirty (30) days prior to the effective date of the termination, the Contractor shall then notify members as soon as possible but no later than fifteen (15) calendar days after receipt of the notification from the practice or practitioner.

Additionally, upon the request of a member, the Contractor shall also provide information on the structure and operation of the health plan as well as information on physician incentive plans in place per 42 CFR 438.10(f)(3) and 42 CFR 438.3(i).

In the first and third quarter of every Contract year, the Contractor shall identify members who are potentially eligible for the Supplemental Nutritional Assistance Program (SNAP). The Contractor shall use the federal poverty level of 130% to identify potentially eligible members. The Contractor shall conduct an educational outreach campaign to the members identified as potentially eligible. The Contractor does not need to outreach to all potentially eligible members at once, but can conduct outreach on a rolling basis during the quarter identified and the following

quarter (e.g., reach out to each potentially eligible member once in the first or second quarter and once again in the third or fourth quarter of every Contract year). The educational information provided to members shall include information on SNAP benefits, eligibility, and how to enroll. The Contractor shall develop communication strategies that meet the requirements of this section, and provide innovative approaches to ensure member understanding of the program. The Contactor shall, at minimum, provide program information to the member through required notices and other communications prescribed by the State.

The Contractor's educational activities and services shall also address the needs of specific program subpopulations (e.g., medically frail, pregnant women, at-risk members, children with special needs) as well as its general membership. The Contractor must have a comprehensive patient outreach strategy to make persons aware of the benefits available to pregnant members and the importance of early and continuous prenatal care. The Contractor shall demonstrate how these educational interventions reduce barriers to health care, social supports, and improve outcomes for members.

The Contractor shall have in place policies and procedures to ensure that materials are accurate in content, accurate in translation relevant to language or alternate formats and do not defraud, mislead or confuse the member. The Contractor shall provide information requested by the State, or the State's designee, for use in member education and enrollment, upon request.

4.4.2 Member and Stakeholder Education and Engagement

The Contractor must convene local and regional member and patient advocacy organization advisory committees and develop strategies to facilitate member participation at least quarterly. The Contractor shall maintain methods to facilitate member and member advocacy organization participation, for example, providing transportation, interpretation services, or personal care assistance. The Contractor shall invite patient advocacy organizations to each meeting, especially focusing on organizations with a focus on special health care needs such as ARC of Indiana, Covering Kids and Families, About Special Kids, and Family Voices.

The committee shall review member materials, including the member handbook and website, and review the Contractor's Health Equity and Cultural Competency plan.

The Contractor shall also develop a formal process for ongoing education of stakeholders prior to, during and after implementation of the HIP program. This includes publicizing methods by which members can ask questions regarding the HIP program. Stakeholders include, but are not limited to, providers, advocates and members. The Contractor shall submit this education plan to FSSA for review and approval in the timeframe and manner determined by the State.

4.4.3 Member Handbook

The Contractor shall develop a member handbook for its HIP members and disseminate it as required under 42 CFR 438.10(g)(3)(i)-(iv). The Contractor is required to provide members notice of any significant change, as defined by the State, in the information specified in the member handbook at least thirty (30) days before the intended effective date of the change per 42 CFR 438.10(g)(4). Within five (5) calendar days of a new member's full enrollment with the Contractor in accordance with Section 4.5, the Contractor shall develop and send the member a Member Handbook. The Contractor's member handbook shall be submitted annually

for FSSA's review, and any time changes are made. The member handbook shall include the Contractor's contact information and Internet website address, and describe the terms and nature of services offered by the Contractor, including the following information required under 42 CFR 438.10(f), which enumerates certain required information. The State provides a model handbook for the Contractor to use when developing their member handbook. The member handbook may be offered in an electronic format as long as the Contractor complies with 42 CFR 438.10(c)(6). The HIP MCE Policies and Procedures Manual outlines the member handbook requirements.

Per 42 CFR 438.10(g)(3)(i)-(iv), member handbook information is considered to be provided to the member if the Contractor:

- Mails a printed copy of the information to the member's mailing address;
- Provides the information by email after obtaining the member's agreement to receive the information by email;
- Posts the information on its website and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; OR
- Provides the information by any other method that can reasonably be expected to result in the member receiving that information.

The HIP member handbook shall include the following:

1. Contractor's contact information (address, telephone numbers, TDD number, website address);
2. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members;
3. The amount, duration and scope of services and benefits available under the Contract in sufficient details to ensure that members are informed of the services to which they are entitled, including, but not limited to the differences between the HIP Plus and HIP Basic benefit options;
4. Information about the EPSDT benefit and how to access services within and outside the Contractor;
5. The procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and other benefits not furnished by the member's primary care provider;
6. Information on accessing transportation including how it is provided for any carved-out benefits per 42 CFR 438.10(g)(2)(i);
7. Contractor's office hours and days, including the availability of a 24-hour Nurse Call Line;
8. Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including

family planning services, from out-of-network providers;

9. The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(g)(2)(v), such as what constitutes an emergency condition or service, the fact that prior authorization is not required for emergency services, and that the enrollee has a right to use any hospital or other setting for emergency care;

10. The post-stabilization care services rules set forth in 42 CFR 422.113(c);

11. The extent to which, and how, urgent care services are provided;

12. Applicable policy on referrals for specialty care and other benefits not provided by the member's PMP, if any;

13. HIP pregnancy policies, including, a description of the HIP Maternity program (MAMA);

14. Information on how and where to access any benefits provided by the State, including any applicable cost cost-sharing policies per 42 CFR 438.10(g)(2)(ii) and 42 CFR 438.10(g)(viii). Additionally, information on HIP cost-sharing policies, including, but not limited to non-payment penalties resulting in transfer to HIP Basic, as well as the exceptions to such non-payment penalties, as detailed in Section 13.7.3;

15. HIP tobacco surcharge for members who use tobacco;

16. HIP co-payments for emergency room services, and the ability to receive a waiver by calling the 24-hour Nurse Call Line prior to utilizing a hospital emergency department;

17. Information about the availability of pharmacy services and how to access pharmacy services;

18. Member rights and protections, as enumerated in 42 CFR 438.100, which relates to enrollee rights. See Section 4.8 for further detail regarding member rights and protections;

19. A description of case manager role and responsibilities;

20. Responsibilities of members;

21. Special benefit provisions (for example, co-payments, deductibles, limits or rejections of claims) that may apply to services obtained outside the Contractor's network;

22. Procedures for obtaining out-of-network services;

23. Standards and expectations to receive preventive health services;

24. Policy on referrals to specialty care;

25. Explanation that the member is not required to obtain a referral before choosing a family planning provider;

26. Procedures for notifying members affected by termination or change in any benefits, services or service delivery sites, including access to the Contractor's transition of care policy and how to access continued services upon transition per 42 CFR 438.62;

27. Procedures for appealing decisions adversely affecting members' coverage, benefits or relationship with the Contractor, including, but not limited to a medically frail determination and tobacco user designation;

28. Information on how to access non-emergency medical transportation and how the member can access assistance with their responsibilities for scheduling, using, and cancelling rides through the Contractor's transportation broker or care management;

29. Procedures for selecting and changing PMPs

30. Standards and procedures for changing MCEs, and circumstances under which this is possible, including, but not limited to providing contact information and instructions for how to contact the enrollment broker to transfer MCEs due to one of the "for cause" reasons described in 42 CFR 438.56(d)(2), including, but not limited to, the following:

    a. Receiving poor quality of care;

    b. Failure to provide covered services;

    c. Failure of the Contractor to comply with established standards of medical care administration;

    d. Lack of access to providers experienced in dealing with the member's health care needs;

    e. Significant language or cultural barriers;

    f. Corrective action or intermediate sanctions levied against the Contractor by the office per 42 CFR 438.56(c)(2)(iv);

    g. Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;

    h. A determination that another MCE's formulary is more consistent with a new member's existing health care needs;

    i. Lack of access to medically necessary services covered under the Contractor's contract with the State;

    j. A service is not covered by the Contractor for moral or religious objections, as described in Section 6.3.2;

    k. Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;

l. The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE;

m. A member that was not given the opportunity to select an MCE in open enrollment may change their MCE during the first 60 days of the new benefit period;

n. A change in aid category; or

o. Other circumstances determined by the State or its designee to constitute poor quality of health care coverage;

31. The process for submitting disenrollment requests. This information shall include the following:

    a. When members may change MCEs (as detailed in Section 4.2)

    b. HIP members may only change MCEs for cause, unless the change is requested prior to either (i) making their initial POWER account contribution or fast track prepayment or (ii) being enrolled in HIP Basic or HIP State Plan Basic in accordance with Section 13.6, whichever occurs first;

    c. Members are required to exhaust the MCE's internal grievance and appeals process before requesting an MCE change due to poor quality of care;

    d. Members may submit requests to change MCEs to the Enrollment Broker verbally or in writing, after exhausting the MCE's internal grievance and appeals process; and

    e. The MCE shall provide the Enrollment Broker's contact information and explain that the member must contact the Enrollment Broker with questions about the process. This information shall include how to obtain the Enrollment Broker's standardized form for requesting an MCE change

    f. The process by which an American Indian/ Alaska Native member may elect to opt- out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for- service benefits through the State;

32. Procedures for making complaints and recommending changes in policies and services;

33. Grievance, appeal and fair hearing procedures as required at 42 CFR 438.10(g)(2)(xi), including the following:

    a. The right to file grievances and appeals;

    b. The requirements and timeframes for filing a grievance or appeal;

    c. The availability of assistance in the filing process;

    d. The toll-free numbers that the member can use to file a grievance or appeal by phone; and

e. The fact that, if requested by the member and under certain circumstances: (1) benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and (2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member;

34. For a State hearing, describe (i) the right to a hearing, (ii) the method for obtaining a hearing, and (iii) the rules that govern representation at the hearing;

35. Information about how to exercise advance directives;

36. How to report suspected fraud or abuse;

37. How to report a change in income, change in family size, etc.;

38. How to request a medically frail determination during the benefit year;

39. Availability and how to access oral interpretation for any language, written translation that is available in prevalent languages, and auxiliary aids and services upon request at no cost for enrollees with disabilities per 42 CFR 438.10(d)(5);

40. Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats;

41. Information on how to contact the Enrollment Broker;

42. Statement that Contractor will provide information on the structure and operation of the health plan;

43. In accordance with 42 CFR 438.10(f)(3), that upon request of the member, information on the Contractor's provider incentive plans will be provided; and

    Information on the annual open enrollment period, from November 1 to December 15th where members may make a new MCE selection effective the next calendar year; and

44. Information on the tobacco surcharge.

4.4.4 Member Website

The Contractor shall provide and maintain a website for members to access information pertaining to the HIP program and the Contractor's services. The website shall be in an FSSA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines. The website shall be live and meet the requirements of this section on the effective date of the Contract. FSSA must pre-approve the Contractor's website information and graphic presentations. The website shall be accurate and current, culturally appropriate, written for understanding at a fifth-grade reading level, in plain language, and available in English and Spanish. The Contractor shall inform members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website shall avoid

techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor must make a version available in a format that is optimized for mobile phone use.

The Contractor shall date each web page, change the date with each revision and allow users print access to the information. The website must include the information required in the Enrollment Packet as described in Section 4.2.2. Such website information shall include, at minimum, the following:

- The Contractor's searchable provider network identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access and other demographic information as described in Section 5.11. The Contractor must update the on-line provider network information every two (2) weeks, at a minimum;
- The Contractor's contact information for member inquiries, member grievances and appeals;
- The Contractor's member services phone number, TDD number, hours of operation and after-hours access numbers, including the 24-hour Nurse Call Line;
- A member portal with access to electronic Explanation of Benefit (EOB) statements. For HIP members, the member portal shall also include up-to-date POWER Account balance information, including the required annual and monthly contribution amounts and payments made for HIP Plus or HIP State Plan Plus members;
- Information about the cost and quality of health care services, as further described in Section 4.4.8;
- A description of the Contractor's disease management programs and care coordination services;
- The member's rights and responsibilities, as enumerated in 42 CFR 438.100. Please see Section 4.8 for further details regarding member rights;
- The member handbook;
- Contractor-distributed literature regarding all health or wellness promotion programs that are offered by the Contractor;
- Contractor's marketing brochures and posters;
- The Health Insurance Portability and Accountability Act (HIPAA) privacy statement;
- Links to FSSA's website for general Medicaid and HIP information;
- Per 42 CFR 438.10(i), information on pharmacy locations and preferred drug lists applicable to each program and benefit package in a machine-readable file and format as specified by the Secretary per 42 CFR 438.10(i)(3) and 42 CFR 457.1207;

- List of all prior authorization criteria for prescription drugs, including mental health drugs;
- Transportation access information
- Information about how HIP State Plan and HIP Plus members may access dental services and how to access the Contractor's dental network;
- A list and brief description of each of the Contractor's member outreach and education materials;
- The executive summary of Contractor's Annual Quality Assessment and Performance Improvement Program Description Summary Report;
- Information on behavioral health covered services and resources;
- A secure portal through which members may complete the health screening questionnaire described in Section 3.8.1.1;
- Preventive care and wellness information. For HIP, this information shall include the preventive care services that qualify a member for POWER Account rollover; and
- Information on the annual open enrollment period from November 1 to December 15th where members may make a new MCE selection for the next calendar year.

4.4.5 Preventive Care Information

The Contractor is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care evidence-based standards. For HIP and members under twenty-one (21) years of age, this would include information on EPSDT, well-child services and blood lead screenings. For HIP members, these plans shall include reminders that encourage members to obtain the FSSA-recommended preventive services for their age, gender and pre-existing conditions, including an explanation that preventive services are not subject to the member's deductible and that the member may be able to roll over a portion of the member's POWER Account balance in accordance with Section 14.8 if recommended preventive services are obtained. Further information on education requirements for disease specific conditions and disease management, care management and complex case management communications is provided in Section 3.8. The Contractor shall, on an ongoing basis, contact via all appropriate media any member who has not utilized preventive services or has no claims activity within the last 15 months to schedule preventive care.

4.4.6 HIP Member Education

The Contractor shall provide members with general information about the benefits covered under the program. The Contractor shall have policies and procedures in place to ensure that member education information is accurate in content, accurate in translation relevant to language, and do not defraud, mislead, or confuse the member. Member education shall include, but not necessarily limited to the items noted below:

- Information on benefit coverage
- How to access the health care system appropriately (i.e. keeping appointments, appropriate use of Emergency Room services, how to file grievances and appeals)
- Information on covered dental services

The below requirements of this section apply to the Contractor's HIP line of business only.

4.4.6.1 HIP Benefit Plans Education

The Contractor shall educate its members about the HIP program structure. Contractor shall establish a variety of methods, to be approved by FSSA, in which it will educate members about the HIP benefit plans, including transitions between benefit plans. The Contractor's HIP member education should emphasize the importance of consistent and timely POWER account payments in order to maintain access to the HIP Plus plan and its enhanced benefits. This education should also include an explanation of the alternative HIP Basic plan, including the copayment structure which may result in increased cost-sharing as compared to the monthly contributions required under the HIP Plus plan. The Contractor shall develop HIP messaging emphasizing the value proposition created between the HIP benefit plans in order to encourage members to remain in the HIP Plus plan, which is less expensive overall and provides access to more covered services. The Contractor shall also educate members about the 12-month calendar year benefit period and the ability to change MCEs during the open enrollment period that will occur every year from November 1st through December 15th.

4.4.6.2 Power Account Education

The Contractor shall establish a variety of methods, to be approved by FSSA, in which it will provide POWER Account education to members. In educating members about POWER Accounts, the Contractor should emphasize those features of POWER Accounts that help members stay healthy, be value- and cost-conscious and utilize services in a cost-efficient manner. The Contractor shall explain the impact members' health seeking behavior will have on their ability to use a left-over POWER Account balance to reduce the next benefit period's required POWER Account contribution for participation in the HIP Plus benefit plan, which provides access to additional benefits, including vision and dental services.

The Contractor shall also inform all HIP Plus members of their right to obtain a partial rebate of their POWER Account if they leave HIP. This partial rebate is not accessible to members who remain on HIP but are transferred to HIP Basic due to non-payment.

POWER Account educational materials shall include, at minimum, information about:

- The opportunity for employers, nonprofits and other third parties to contribute to member POWER Accounts;
- Non-payment policies, including (i) termination from HIP for

individuals above 100% FPL or transfer to HIP Basic for individuals at or below 100% FPL if a contribution is not received within sixty (60) calendar days of its due date, as described in Section 13.7; (ii) the exceptions to the policies listed in subsection (i) above, as described in Section 13.7.1; (iii) inability for members transferred to HIP Basic to obtain HIP Plus benefits until the member's next eligibility period; (iv) HIP debt policies; and (v) forfeiture of twenty five percent (25%) of remaining POWER Account balance in accordance with Section 13.5;

- Policies regarding how members may report a change in income or family size that may impact their eligibility or benefits;
- POWER Account rollover policies for both HIP Plus and HIP Basic, including information on how members may obtain recommended preventive care; and
- POWER Accounts may not be utilized to pay for HIP Basic copayments or required emergency room copayments.

4.4.7 Cost and Quality Information

Making cost and quality information available to members increases transparency and has the potential to reduce costs and improve quality. The Contractor shall make cost and quality information available to members in order to facilitate more responsible use of health care services and inform health care decision-making. Example cost information includes average cost of common services, urgent versus emergent care costs, etc.

For services that may be at risk for improper payments, the Contractor must develop processes to verify with members that said targeted services billed by providers were actually received by said members, in order to obtain direct verification of services rendered and increase oversight. The Contractor's processes and procedures must be identified in the Contractor's Program Integrity Plan, identified in Section 7.1. Specific services for member verification may be identified by the OMPP PI Section and may change based upon fraud trends. Processes for verifying services with members shall be included in the Contractor's Program Integrity Plan.

The Contractor shall provide a member portal with access to electronic EOB statements for its HIP members. In addition, the Contractor shall generate and mail EOB statements to, at minimum, HIP members on a monthly basis. For HIP members, the EOB statements shall indicate when services are paid with POWER Account funds. The POWER Account Statement required in Section 14.4 and EOB information may be combined in a single statement for HIP members. The Contractor shall give HIP members an opportunity to receive e-mail alerts about EOB information on the member's secure web portal, in addition to or as an alternative to receiving the information by mail.

Provider quality information shall also be made available to members. The Contractor must capture quality information about its network providers, and shall make this information available to members. In making the information available to members, the Contractor shall identify any limitations of the data. The Contractor shall also refer members to quality information compiled by credible external entities (e.g., Hospital Compare, Leap Frog Group, etc.).

4.5 Member and Potential Member Communications Review and Approval

All member and potential member communications required in this section or otherwise developed by the Contractor must be pre-approved by FSSA. The Contractor shall develop and include a Contractor-designated inventory control number on all member marketing, education, training, outreach and other member materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate FSSA's review and approval of member materials and document its receipt and approval of original and revised documents.

The Contractor shall submit all member and potential member communications, including letters, bulletins, forms, advertisements, notices, handbooks, brochures and any other marketing, educational or outreach materials to FSSA for review and approval at least thirty (30) calendar days prior to expected use and distribution. Substantive changes to member and potential member communications shall also be submitted to FSSA for review and approval at least thirty (30) calendar days prior to use.

The Contractor shall not refer to or use the FSSA or other state agency name or logo in its member and potential member communications without prior written approval. The Contractor shall request in writing approval from FSSA for each desired reference or use at least thirty (30) calendar days prior to the reference or use. Any approval given for the FSSA or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval. The Contractor shall include the State program logo(s) in their marketing or other member communication materials upon FSSA request.

FSSA will assess liquidated damages as set forth in Exhibit 2.B and impose other authorized remedies for the Contractor's non-compliance in the use or distribution of any non-approved member or potential member communications.

All FSSA-approved member and potential member communication materials shall be available on the Contractor's member website within three (3) business days of distribution.

Per 42 CFR 438.10(c)(4)(ii), the Contractor is required to use State developed enrollee notices when notified by FSSA.

4.6 Redetermination Assistance

Contractors may assist members in the eligibility redetermination process. Contractors will receive the member's redetermination date on the 834. Permitted assistance includes:

- Conducting outreach calls or sending letters to members reminding them to renew their eligibility and reviewing redetermination requirements with the member;
- Answering questions about the redetermination process; and
- Helping the member obtain required documentation and collateral verification needed to process the application.
- Refer the member with any eligibility related questions to the DFR.

In providing assistance during redetermination, Contractors shall be prohibited from the following:

- Discriminate against members, particularly high-cost members;
- Talk to members about changing MCEs (if a member has questions or requests to change MCEs, the Contractor shall refer the member to the Enrollment Broker), members may be educated about the once annual open enrollment period and advised that they are not eligible to change

due to redetermination;
- Provide any indication as to whether the member will be eligible (this decision shall be made by DFR);
- Engage in or support fraudulent activity in association with helping the member complete the redetermination process;
- Sign the member's redetermination form; or
- Complete or send redetermination materials to DFR on behalf of the member.

Contractors shall provide redetermination assistance equally across the membership and be able to demonstrate to FSSA that their redetermination-related procedures are applied consistently for each member.

4.7 Member-Provider Communications

The Contractor shall comply with 42 CFR 438.102(a)(1) and section1932(b)(3)(A) of the Social Security Act, which relates to provider-enrollee communications. The Contractor shall not prohibit or otherwise restrict a health care professional, acting within his or her lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding the following:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under the HIP program;

- Any information the member needs in order to decide among all relevant treatment options;

- The risks, benefits, and consequences of treatment or non-treatment; and

- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

This provision does not require the Contractor to provide coverage for a counseling or referral service if the Contractor objects to the service on moral or religious grounds in accordance with 42 CFR 438.102(a)(2) and section 1932(b)(3)(B)(i) of the Social Security Act. The Contractor may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal as required by 42 CFR 438.410(b).

4.8 Member Rights

The Contractor shall guarantee the following rights protected under 42 CFR 438.100 to its members:

- The right to receive information on the managed care program and plan into which he/she is enrolled per 42 CFR 438.100(a)(1) and 42 CFR 438.100(b)(2)(i);

- The right to receive information in accordance with 42 CFR 438.10, which relates to informational materials;

- The right to be treated with respect and with due consideration for his or her dignity and privacy per 42 CFR 438.100(a)(1) and 42 CFR 438.100(b)(2)(ii);

- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to

understand in accordance with 42 CFR 438.3(j)(2), 42 CFR 438.100(a)(1) and 42 CFR 438.100(b)(2)(iii);

- The right to participate in decisions regarding his or her health care, including the right to refuse treatment in accordance with 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(iv);

- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion in accordance with 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(v);

- The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(vi) and the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information; and

- The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

The Contractor shall also comply with other applicable state and federal laws regarding member rights, as set forth in 42 CFR 438.100(d) and 42 CFR 438.100(a)(2).

The Contractor shall have written policies in place regarding the protected member rights listed above. The Contractor shall have a plan in place to ensure that its staff and network providers take member rights into account when furnishing services to the Contractor's members.

Members shall be free to exercise protected member rights, and the Contractor shall not discriminate against or treat adversely, a member that chooses to exercise his or her rights in accordance with 42 CFR 438.100(a)(1) and 42 CFR 438.100(c).

4.9 Member Grievances and Appeals

In compliance with 42 CFR 438.402(c)(1) and 42 CFR 438.408, the Contractor shall allow members to file appeals, grievances, and State fair hearing requests (after receiving notice that an adverse benefit determination is upheld). The Contractor shall allow providers, or authorized representatives, acting on behalf of the member and with the member's written consent, to request an appeal, file a grievance, or request a State fair hearing request per 42 CFR 438.402(c)(1) and 42 CFR 438.408. The Contractor cannot require providers and/or members to use a specific form to submit an appeal.

The Contractor shall have a grievance and appeals system in place in accordance with 42 CFR 438.402(a) and 42 CFR 438.228 and establish written policies and procedures governing the process and resolution of grievances and appeals. At a minimum, the grievance system shall include a grievance process, a single-level appeal process, expedited review procedures, external review procedures and access to the State's fair hearing system. The Contractor's grievances and appeals system, including the policies for recordkeeping and reporting of grievances and appeals, shall comply with 42 CFR 438, Subpart F, which relates to the Contractor's grievance system, as well as IC 27-13-10 and IC 27- 13-10.1 (if the Contractor is licensed as an HMO) or IC 27-8-28 and IC 27-8-29 (if the Contractor is licensed as an accident and sickness insurer), as described within the HIP

MCE Policies and Procedures Manual.

The term *inquiry* refers to a concern, issue or question that is expressed orally by a member that will be resolved by the close of the next business day.

The term *grievance,* as defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an "adverse benefit determination" as defined below. This may include dissatisfaction related to the quality of care of services rendered or available, aspects of interpersonal relationships such as rudeness of a provider or employee or the failure to respect the member's rights. A grievance is a complaint about the way a member's health plan is giving care. For example, a member may file a grievance if the member has a problem calling the plan or if the member is unhappy with the way a staff person at the plan has behaved toward them. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see appeal).

The term *appeal*, per 42 CFR §438.400(b), is defined as a request for a review of an adverse benefit determination. An appeal is a special kind of complaint a member may make if they disagree with a decision to deny a request for health care services or payment for services they've already received. A member may also make a complaint if they disagree with a decision to stop services that they are receiving. For example, a member may ask for an appeal if Medicare doesn't pay for an item or service they think they should be able to get. There is a specific process that a member's health plan must use when they ask for an appeal.

An adverse benefit determination, as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service excluding the denial of a claim that does not meet the definition of a clean claim. A "clean claim" is one in which all information required for processing the claim is present;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of a Contractor to act within the required timeframes;
- For a resident of a rural area with only one Contractor, the denial of a member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network (if applicable); or
- Denial of a member's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

In accordance with 42 CFR 438.10(c), the Contractor shall notify the requesting provider, and give the member written notice, of any decision considered an "action" taken by the Contractor, including, but not limited to any decision by the Contractor (i) to deny a service authorization request, (ii) to authorize a service in an amount, duration or scope that is less than requested, or (iii) that is adverse to the member regarding a medically frail designation. The notice shall meet the requirements of 42 CFR 438.404, "Notice of Action." See Section 6.3.1, Authorization of Services and Notices of Action for additional information. The notice must meet the requirements of 42 CFR 438.404(b) and 42 CFR 438.402(b)-(c), and must

include:

- The adverse benefit determination the Contractor has taken or intends to take;
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination;
- The member's or the provider's right to request an appeal and the procedure for requesting such an appeal, including information on exhausting the Contractor's one level of appeal;
- The procedure to request an external grievance procedure (External Review by Independent Review Organization) following exhaustion of the Contractor appeals process;
- The procedure to request a State fair hearing following exhaustion of the Contractor appeals process;
- The circumstances under which expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending resolution of the appeal, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services.

4.9.1 Contractor Grievance and Appeals Policies

The Contractor's policies and procedures governing grievances and appeals shall include provisions which address the following:

- The Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member, in accordance with 42 CFR 438.102, which relates to provider-enrollee communications. A provider, acting on behalf of the member and with the member's written consent, may file an appeal;
- The Contractor shall not take punitive action against a provider who requests or supports an expedited appeal on behalf of a member;
- Throughout the appeals process, the Contractor shall consider the member, representative or estate representative of a deceased member as parties to the appeal per 42 CFR 438.406(b)(6);
- In accordance with 42 CFR 438.406(b)(5), provide the member and member representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process;
- Allow the member and member representative to present evidence, and allegations of fact or law, in person as well as in writing per 42 CFR 438.406(b)(4);

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- Inform the member and member representative of the limited time available to present evidence and allegations of fact or law, in the case of expedited appeal resolution per 42 CFR 438.406(b)(4) and 42 CFR 438.408(b);

- Upon determination of the appeal, ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The Contractor's appeal decision notice shall describe the actions taken, the reasons for the action, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e), which enumerates required content of a notice of resolution;

- The Contractor must acknowledge receipt of each grievance and appeal in accordance with 42 CFR 438.406(b)(1) and 42 CFR 438.228(a);

- The Contractor must ensure that decision makers take into account all comments documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination per 42 CFR 438.406(b)(2)(iii) and 42 CFR 438.228(a);

- The Contractor shall notify members of the disposition of grievances and appeals pursuant to IC 27-13-10-7 (if the Contractor is licensed as an HMO) or IC 27-8-28-16 (if the Contractor is licensed as an accident and sickness insurer);

- The Contractor shall provide members any reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability in accordance with 42 CFR 438.406(a) and 42 CFR 438.228(a);

- In accordance with 42 CFR 438.228(a), the Contractor shall ensure that the individual rendering the decision on grievances and appeals were not involved in previous levels of review or decision-making or subordinates of any individual who was involved in a previous level of review or decision making per 42 CFR 438.406(b)(2)(i), and in accordance with 42 CFR 438.406(b)(2)(ii)(A) - (C), are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; (iii) any grievance or appeal involving clinical issues; and

- The Contractor shall ensure that the individual rendering the decision on appeals related to the Contractor's medically frail determination are licensed physicians.

- In accordance with 42 CFR 438.408 and 42 CFR 438.402(c)(1)(i)(A), if the Contractor fails to adhere to notice and timing requirements, the member is deemed to have exhausted the Contractor's appeals process and the enrollee may initiate a State fair hearing.

4.9.2 Inquiry Processing Requirements

The Contractor shall resolve inquiries by the close of the next business day after receipt. If an inquiry is not resolved in this timeframe, it becomes a grievance. An inquiry resolved in the required timeframe does not require a written notice of resolution to the member. The Contractor shall maintain a system for tracking and reporting inquiries it receives during business and non-business hours.

4.9.3 Grievance Processing Requirements

In accordance with 42 CFR 438.402(c)(2)(i) and 42 CFR 428.402(c)(3)(i), members shall be allowed to file grievances orally or in writing at any time. Members may file a grievance regarding any matter other than those described in the definition of an action as described in this Section 4.9.

The Contractor shall acknowledge receipt of each grievance within three (3) business days. In accordance with 42 CFR 438.408(a) and 42 CFR 438.408(b)(1), the Contractor shall make a decision on non-expedited grievances as expeditiously as possible, but not more than thirty (30) calendar days following receipt of the grievance. This timeframe may be extended up to fourteen (14) calendar days if the enrollee requests the extension or the Contractor shows there is need for additional information and the delay is in the member's interest (upon State request) as required by 42 CFR 438.408(b)(1) and 438.408(c)(1). In accordance with 42 CFR 438.408(b)(1) and 42 CFR 438.408(c)(2), and if the timeframe is extended, for any extension not requested by the member, the Contractor shall make reasonable efforts to give the enrollee prompt oral notice of the delay and give the member written notice of the reason for the delay within two (2) calendar days of the extension, including the reason for the extension and the member's right to file a grievance if they disagree with the extension.

The Contractor shall provide an expedited grievance review if adhering to the resolution timeframe of thirty (30) calendar days would seriously jeopardize the life or health of a member, or the member's ability to regain maximum function. Expedited grievances shall be resolved within forty-eight (48) hours of receipt. If the Contractor denies a request for an expedited review, the Contractor shall transfer the grievance to the standard grievance timeframe per 42 CFR 438.410(c), 42 CFR 438.408(b)(2), and 42 CFR 438.408(c)(2). Further, the Contractor shall make a reasonable effort, including a phone call to the member, to provide the member with prompt oral notification of the denial for an expedited review, and shall follow up with a written notice within two (2) calendar days.

The Contractor shall respond in writing to a member within five (5) business days after resolving a grievance or expedited grievance. The notice shall be in a format and language that meets notifications standards per 42 CFR 438.408(d)(1) and 42 CFR 438.10. The resolution includes notice of the member's right to file an appeal if applicable, the process for requesting an appeal, the expedited review options, the right to continue benefits during the appeal (as long as the request complies with timeliness standards), and an explanation that the member may have to pay for care received if an adverse appeal decision is made. The Contractor shall make a reasonable effort, including a phone call to the member, to provide oral notification of expedited grievance resolution.

4.9.4 Appeals Processing Requirements

Members, or providers acting on the member's behalf, shall have sixty (60) calendar

days from the date of action notice within which to file an appeal per 42 CFR 438.402(c)(2)(ii). In accordance with 42 CFR 438.402, a provider, acting on behalf of the member and with the member's written consent, may file an appeal. In accordance with 42 CFR 438.402(c)(1)(ii), and 42 CFR 438.402(c)(3)(ii), members, the provider, or authorized representative shall be allowed to request an appeal or file grievances orally or in writing.

In accordance with 42 CFR 438.406(b)(3), the Contractor shall ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. For oral appeals with expedited resolutions the Contractor shall maintain documentation of the oral appeal and its resolution.

The Contractor shall acknowledge receipt of each standard appeal within three (3) business days. The Contractor shall resolve each appeal and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to exceed thirty (30) calendar days from the day the Contractor receives the appeal per 42 CFR 438.408(a) and 42 CFR 438.408(b)(2). The Contractor shall make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days if the member requests the extension, or if the Contractor shows that there is need for additional information and that delay is in the member's interest (upon State request), pursuant to 42 CFR 438.408(c)(1) and 42 CFR 438.408(b)(2). In accordance with 42 CFR 438.408(c)(2) and 42 CFR 438.408(b), if the timeframe is extended, for any extension not requested by the member, the Contractor shall make reasonable efforts to give the member prompt oral notice of the delay and give the member written notice, within two (2) calendar days, and include the reason for the decision and inform the member of their right to file a grievance if he or she disagrees with that decision of the reason for the delay.

In accordance with 42 CFR 438.410(a), the Contractor shall maintain an expedited review process for appeals when the Contractor or the member's provider determines that pursuing the standard appeals process could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. In accordance with 42 CFR 438.408(a) and 42 CFR 438.408(b)(3), the Contractor shall resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and shall dispose of expedited appeals within forty-eight (48) hours after the Contractor receives notice of the appeal. The Contractor may extend the timeframe for processing an expedited appeal by up to fourteen (14) calendar days if the enrollee requests the extension or if the Contractor shows that there is need for additional information and that the delay is in the member's interest (upon State request) per 42 CFR 438.408(c)(1)(i)-(ii) and 42 CFR 438.408(b)(3). If the timeframe is extended, for any extension not requested by the member, the Contractor shall make reasonable efforts to give the member prompt oral notice of the delay and give the member written notice, within two (2) calendar days, and include the reason for the decision and inform the member of their right to file a grievance if he or she disagrees with that decision.

In accordance with 42 CFR 438.410, if the Contractor denies the request for an expedited resolution of a member's appeal, the Contractor shall transfer the appeal to the standard thirty (30) calendar day timeframe and give the member written notice of the denial within two (2) days of the expedited appeal request. The Contractor shall also make a reasonable attempt to give the member prompt oral notice, including a phone call to the member.

In compliance with 42 CFR 438.408(b)-(c), the Contractor shall provide the member

or representative, the member's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions in compliance with Indiana law and no longer than thirty (30) calendar days from the day the Contractor receives the appeal. This time period is reduced to seventy-two (72) hours from the day the Contractor receives an expedited appeal.

In accordance with 42 CFR 438.408(d)(2)(ii), written notice of appeal disposition shall be provided to the member and for notice of an expedited resolution, the Contractor shall also make reasonable efforts, including a phone call to the member, to provide oral notice. Notice shall be provided within five (5) business days of resolution. In accordance with 42 CFR 438.408(d)(2)(i), 42 CFR 438.10, and 42 CFR 438.408(e)(1)-(2), the written notice of the resolution shall include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice shall include the right to request an external grievance procedure (External Review by Independent Review Organization) and State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. This shall also include notice that the member may be held liable for the cost of those benefits if the State hearing upholds the Contractor's action as set forth in Section 4.9.7.

For member adverse action appeals related to the Contractor's medically frail determination that result in a reduction of the member's benefit package (for example, a member is determined no longer medically frail at annual redetermination), the Contractor must ensure continuation of State Plan benefits upon appeal, provided the member timely files the appeal before the expiration of their State Plan benefits. To ensure continuation of State Plan benefits during appeal, the Contractor should send a frail = 'Y' indicator through the State's fiscal agent. The Contractor must maintain documentation of the appeal record, and when the supplemental file is implemented, input a frail confirmation reason specifying that the member frail indicator was changed to 'Y' because of appeal. Members that appeal after the expiration of their benefits are not entitled to continuation of medically frail benefits during the appeal, and the Contractor should not send a frail 'Y' during the appeal for these members.

If members were mistakenly identified as tobacco users, the member can appeal tobacco use designations through the Contractor. Tobacco use designation is not an eligibility factor; therefore, it is not directly appealable to FSSA. The Contractor shall provide notice to the State via the *Core*MMIS system within one (1) business day of receipt of the appeal.

4.9.5 External Review by Independent Review Organization

In accordance with IC 27-13-10.1-1 and IC 27-8-29-12 and 42 CFR 438.402(c)(1)(i)(B), the Contractor shall maintain an external grievance procedure for the resolution of decisions related to an adverse utilization review determination, an adverse determination of medical necessity, or a determination that a proposed service is experimental or investigational. Members must first exhaust the Contractor's grievance and appeals process. An external review does not inhibit or replace the member's right to appeal a Contractor decision to a State fair hearing. A member may seek external review by an IRO, and such process may run concurrently with a State fair hearing.

Within one hundred and twenty (120) calendar days of receipt of the appeal decision, a member, or a member's representative may file a written request for a review of the

Contractor's decision by an independent review organization (IRO). The IRO shall render a decision to uphold or reverse the Contractor's decision within seventy-two (72) hours for an expedited appeal, or fifteen (15) business days for a standard appeal. The determination made by the independent review organization is binding on the Contractor. IRO clinicians do not have to be Indiana-licensed.

4.9.6 State Fair Hearing Process

In accordance with 42 CFR 438.408, the State maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions to the State. Appeal procedures for applicants and recipients of Medicaid are found at 405 IAC 1.1. The State fair hearing procedures include the requirements described in this Section 4.9.6.

Members must first exhaust the Contractor's grievance and appeals process. The Contractor must timely coordinate the grievance and appeal process. The member may request a State fair hearing within one hundred and twenty (120) calendar days from the date of the Contractor's decision. As noted above, this process may run concurrent to an external review by an IRO.

The parties to the FSSA fair hearing shall include the Contractor, as well as the member and his or her representative or the representative of a deceased member's estate per 42 CFR 438.406(b)(6). The Contractor shall respond to all requests for documentation required for the FSSA fair hearing within the timeframe identified in the request. In addition, if requested by FSSA at least five (5) business days in advance, the Contractor shall send a representative to the FSSA fair hearing to represent the State. Contractor will be subject to the contract compliance remedies set forth in Exhibit 2.B for failing to either (i) provide a timely and satisfactory response to documentation required for an appeal or (ii) to represent the State at the FSSA fair hearing upon adequate notice. Adequate notice, at a minimum, requires notice of hearing mailed by the Indiana Office of Administrative Law Proceedings, or in the alternative, a request sent directly to the Compliance Officer by the Office of Medicaid Policy and Planning.

If dissatisfied with the outcome of the State fair hearing, the member may request an agency review within ten (10) days of receipt of the administrative law judge's decision. Pursuant to 405 IAC 1.1-3-1, if the member is not satisfied with the final action after agency review, the member may file a petition for judicial review in accordance with IC 4-21.5-5. The MCE may request an agency review of a decision made by an administrative law judge, at the Contractor's discretion.

The Contractor must include the external grievance procedure (External Review by Independent Review Organization) and the FSSA fair hearing process as part of the written internal process for resolution of appeals and must describe the fair hearing process in the member handbook. All notices of actions with appeal rights and notices of final action by the Contractor where the next course of action is a State Fair Hearing shall have the following language included:

"This is an administrative action by the State of Indiana. If you disagree with this decision, you can appeal it. Appeals are handled by the State of Indiana Office of Administrative Law Proceedings. You may mail your request for a state fair hearing to the State of Indiana Office of Administrative Law Proceedings at:

Office of Administrative Law Proceedings
100 N. Senate Ave., Room N802
Indianapolis, IN 46204
Fax: 317-232-4412
Email: fssa.appeals@oalp.in.gov

4.9.7 Continuation of Benefits Pending Appeal & Reinstatement of Benefits

In certain member appeals, the Contractor will be required to continue the member's benefits pending the appeal, in accordance with 42 CFR 438.420(a), 42 CFR 438.420(b), and 42 CFR 438.402(c)(2)(ii). The Contractor shall continue the member's benefits if:

- The member or provider files the request for an appeal within sixty (60) days following the date on the adverse benefit determination notice;
- The member or provider files the request for continuation of benefits within ten (10) days of the Contractor mailing the notice or the intended effective date of the proposed adverse benefit determination, whichever is later;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The member requests extension of benefits.

If benefits are continued or reinstated while the appeal is pending, per 42 CFR 438.420(c); 42 CFR 438.408(d)(2), the benefits shall be continued until one of the following occurs:

- The member withdraws the request;
- The member does not request a State fair hearing and continuation of benefits within sixty (60) calendar days from the date the Contractor sends the notice of an adverse appeal resolution;
- A State fair hearing decision adverse to the enrollee is issued; or
- The service limits of a previously authorized services have been met.

If the final resolution of the appeal is adverse to the member, that is, it upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements to maintain benefits in accordance with 42 CFR 431.230(b) and 42 CFR 438.420(d). The Contractor shall notify the member in advance that costs may be recovered.

In accordance with 42 CFR 438.424, if the Contractor or State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services

promptly, and as expeditiously as the member's health condition requires (but no later than seventy-two (72) hours from the date it receives notice reversing the decision). If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor shall pay for those services.

4.9.8 Member Notice of Grievance, Appeal and Fair Hearing Procedures

The Contractor shall provide specific information regarding member grievance, appeal, external grievance procedure (External Review by Independent Review Organization), and State fair hearing procedures and timeframes to members, as well as providers and subcontractors at the time they enter a contract with the Contractor. This information shall be included in the Member Handbook as described in Section 4.4.3. The information provided shall be approved by FSSA in accordance with Section 4.5, and, as required under 42 CFR 438.10(g)(2)(xi), include the following:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the member can use to file a grievance or appeal by phone;
- The fact that, if requested by the member and under certain circumstances: 1) benefits will continue if the member files an appeal or requests a FSSA fair hearing within the specified timeframes; and 2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member;
- The right to request an External Review by an Independent Review Organization of decisions listed in 4.9.5; and
- In the case of an FSSA fair hearing:
    - The right to a hearing;
    - The method for obtaining a hearing; and
    - The rules that govern representation at the hearing.

4.9.9 Recordkeeping Requirements of Grievances and Appeals

For purposes of quality review, and in accordance with 42 CFR 438.416(a) and 42 CFR 438.416(b)(1)-(6), the Contractor shall accurately maintain records for grievances and appeals that contain, at minimum, the following information:

- A general description of the reason for the appeal or grievance;
- The date the appeal or grievance was received;
- The date the appeal or grievance was reviewed;
- The resolution of the appeal or grievance;

- The date of the resolution of the appeal or grievance; and
- The name and MID number of the member for whom the appeal or grievance was filed.

The Contractor shall provide such record(s) of grievances and appeals upon request by FSSA per 42 CFR 438.416(c).

4.10 Oral Interpretation Services

In accordance with 42 CFR 438.10(d), the Contractor shall arrange for oral interpretation services to its members free of charge for services it provides, including, but not limited to:

- Member services helpline;
- Twenty-four (24) hour nurse call line;
- Transportation;
- Assessment and stratification;
- Disease management;
- Care management;
- Complex case management; and
- Right Choices Program.

The requirement to provide oral interpretation applies to all non-English languages, and is not limited to prevalent languages discussed in Section 4.4. Oral interpretation services shall include sign language interpretation services for the deaf. The Contractor shall notify its members of the availability of these services and help them to arrange them.

Additionally, the Contractor shall ensure that its provider network arranges for oral interpretation services to members seeking healthcare-related services in a provider's service location. This includes ensuring that providers who have twenty-four (24) hour access to healthcare-related services in their service locations or via telephone (e.g., hospital emergency departments, PMPs) shall provide members with twenty-four (24) hour oral interpreter services, either through interpreters or telephone services. For example, the Contractor shall ensure that network providers provide TDD services for hearing impaired members, oral interpreters, and signers.

4.11 Health Equity

In accordance with 42 CFR 438.206(c)(2), the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Per 42 CFR 438.206(c)(2), at the time of enrollment with the Contractor, the State shall provide the race, ethnicity and primary language of each member. This information shall be utilized by the Contractor to ensure the delivery of culturally competent services. Furthermore, the Contractor will ensure all services are delivered through a health equity lens. The MCP shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Medicaid-insured individuals and from providers of direct services which are intended to reduce adverse health outcomes among Medicaid insured individuals, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts. The Contractor will utilize Community Health Workers as part of broader community health integration initiatives and promotion of culturally competent care.

EXHIBIT 1B

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The Contractor shall submit an annual health equity plan for FSSA approval which incorporates the Office of Minority Health's National Standards on Culturally and *Linguistically* Appropriate Services (CLAS). The CLAS standards are available at https://thinkculturalhealth.hhs.gov/clas/standards.

The plan shall include at a minimum:

- How the health equity officer and support staff engage with member and organization advisory groups to ensure members can participate in program improvement planning and related activities.
- Incorporation of the CLAS enhanced standards adopted by the Department of Health and Human Services and linked to herein.
- A foundational assessment of health equity within the Contractor's membership population, including detail on inequities in accessing care in the member's setting of choice.
- A description of how the health plan will ensure that services are provided in a culturally competent and trauma-informed manner to all members so that all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, understand their condition(s) or needs, the recommended treatment(s), and the effect of the treatment or service on their condition, including side effects. See additional details set forth in Section 5.1.2 Access to Culturally and Linguistically Competent Providers.
- A description of how the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds and national origins, geographies, sexual orientations, gender identities, abilities, and religions in a manner that recognizes, affirms and respects the worth of the individual members and protects and preserves the dignity of each member.
- Identification of inequities and their root causes for the Contractor's membership including inequities that arise with certain diagnoses, the development of targeted interventions that are trauma informed and measures to reduce these inequities, and a description of how to evaluate progress in disparity reduction efforts will be collected and analyzed.
- The utilization of Community Health Workers as part of broader community health integration initiatives and promotion of culturally competent care.
- A training plan in equity and cultural competency for the Contractor's staff. Documentation of periodic training shall be provided in the annual assessment.

The plan shall be assessed by the Contractor annually and submitted to FSSA by August 1 for calendar year 2023 and by January 31 for all remaining calendar years of the contract period. The assessment shall provide the outcome measures used to measure progress in the prior year, and any new interventions the Contractor will incorporate in the next year.

The MCE shall follow the guidance provided by the National Committee for Quality Assurance (NCQA) regarding the stratification of HEDIS measures by race and ethnicity.

The Contractor shall ensure that all subcontractor's services and sites are physically and digitally accessible, following the Americans with Disabilities Act (ADA) and Section 508 of the Rehabilitation Act (Section 508) and that all subcontractors are culturally competent.

4.12 Advance Directive Information

The Contractor shall comply with the requirements of 42 CFR 422.128 and 42 CFR 489.102(a), which relates to advance directives, for maintaining written policies and procedures for advance directives. The Contractor shall maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the Contractor's health plan. Specifically, each Contractor shall maintain written policies and procedures that meet requirements for advance directives in Subpart I of 42 CFR 489. Advance directives are defined in 42 CFR 489.100 as "a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Written policies shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. Such statement must clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians, identify the state legal authority permitting such objection and describe the range of medical conditions or procedures affected by the conscience objection.

Written information on the Contractor's advance directive policies, including a description of applicable state law, shall be provided to members in accordance with 42 CFR 438.10(g)(2) and 42 CFR 438.3(j), which together require written policies around advance directives. Written information shall include their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Written information shall reflect changes in state law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change.

This information shall be provided at the time of initial enrollment. If the member is incapacitated at the time of initial enrollment and is unable to receive information or articulate whether or not he or she has executed an advance directive, the information may be given to the member's family or surrogate. Once the member is no longer incapacitated or unable to receive such information, the Contractor shall ensure the information is given to the individual directly at the appropriate time. Members shall also be informed that complaints concerning noncompliance with the advance directive requirements may be filed with the State. See 42 CFR 422.128 for further information regarding these requirements.

The Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive per 42 CFR 438.3(j)(1)-(2), 42 CFR 422.128(b)(1)(ii)(F) and 42 CFR 489.102(a)(3).

5.0 Provider Network Requirements

The Contractor shall develop and maintain a provider network in compliance with the terms of this section. Per 42 CFR § 438.2, a network provider is any provider, group of providers, or entity that has a network provider agreement with the Contractor, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the Contract with the Contractor. A network provider is not a subcontractor by virtue of the network provider agreement.

In accordance with 42 CFR 438.3(1) the Contractor must allow each member to choose his or her health professional to the extent possible and appropriate. The Contractor shall ensure that its provider network is supported by written provider agreements, is available and geographically

accessible and provides adequate numbers of facilities, physicians, pharmacies, ancillary providers, service locations and personnel for the provision of high- quality covered services for its members, in accordance with 42 CFR 438.206, which relates to availability of services. The Contractor shall also ensure that all of its contracted providers can respond to the cultural, racial and linguistic needs of its member populations. The network shall be able to handle the unique needs of its members, particularly those with special health care needs. The Contractor will be required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner.

The Contractor shall ensure all network providers who, in accordance with IHCP policy, are provider types eligible and required to enroll as an IHCP provider, are enrolled IHCP Medicaid providers, consistent with provider disclosure, screening, and enrollment requirements per 42 CFR 438.608(b), 42 CFR 455.100-106, and 42 CFR 455.400-470. Per IC 27-13-1-24, a participating provider means a provider who, under an express or implied contract with: (1) the health maintenance organization; or (2) a contractor of the health maintenance organization or any subcontractor of a contractor of the health maintenance organization; has agreed to provide health care services to enrollees with an expectation of directly or indirectly receiving payment, other than copayment or deductible, from the health maintenance organization.

The Contractor shall not contract with providers that the State has determined have been terminated from the Medicare, Medicaid or CHIP programs pursuant to 42 CFR 455.101 and section 1932(d)(5) of the Social Security Act.

The State will screen and enroll, and periodically revalidate all Contractor network providers as Medicaid providers in accordance with 42 CFR 438.602(b)(1). The Contractor may execute provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to one hundred and twenty (120) days but must terminate a network provider immediately upon notification from the State that the provider cannot be enrolled, or the expiration of a one hundred and twenty (120) day period without enrollment of the provider, and notify affected enrollees per 42 CFR 438.602(b)(2).

In some cases, members may receive out-of-network services. A non-participating provider is a provider who does not accept assignment on all Medicaid claims. To receive reimbursement from the Contractor, out-of- network providers shall be IHCP providers. The Contractor shall encourage out-of-network providers to enroll in the IHCP, particularly emergency services providers, as well as providers based in non-traditional urgent health care settings such as retail clinics. An out-of-network provider shall be enrolled in the IHCP in order to receive payment from the Contractor. Further information about IHCP Provider Enrollment is located at: https://www.in.gov/medicaid/providers/973.htm.

5.1 Network Development

FSSA requires the Contractor to develop and maintain a comprehensive network to provide services to its HIP members. The Contractor shall implement written policies and procedures for selection and retention of network providers as required by 42 CFR 438.12(a)(2) and 42 CFR 438.214(a). The network shall include providers serving special needs populations. For its HIP population, the provider network shall not be any more restrictive for HIP Basic members than for HIP Plus members.

The Contractor shall develop a comprehensive network prior to the effective date of the Contract. The Contractor shall be required during the readiness review process to demonstrate network adequacy through the submission of Geo Access reports in the manner and timeframe required by FSSA. The Contractor shall be required to have an open network and accept any IHCP provider acting within his or her scope of practice until the Contractor demonstrates that it meets the access requirements. FSSA reserves the

right to delay initial member enrollment in the Contractor's plan if the Contractor fails to demonstrate a complete and comprehensive network.

With approval from FSSA, Contractors that can demonstrate that they have met all access, availability and network composition requirements may require members to use in-network providers, with the exception of certain self-referral providers as described in Section 3.2. The Contractor shall provide ninety (90) calendar day advance notice to FSSA of changes to the network that may affect access, availability and network composition. FSSA shall regularly and routinely monitor network access, availability and adequacy. FSSA shall impose remedies, as set forth in Exhibit 2.B, or require the Contractor to maintain an open network, if the Contractor fails to meet the network composition requirements.

In accordance with 42 CFR 438.206(b)(1), the Contractor shall maintain and monitor the provider network and establish written agreements with all network providers as further described in Section 5.4. In establishing and maintaining the network, the Contractor shall consider the following elements:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of the Contractor's and HIP members enrollment and anticipated enrollment;
- The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;
- The numbers of network providers who are not accepting new members;
- The proximity to public transportation and/or the reliance upon non-emergency medical transportation; and
- The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for members with disabilities.

FSSA shall assess liquidated damages as set forth in Exhibit 2.B and shall impose other authorized remedies, such as requiring the Contractor to maintain an open network, for Contractor's non- compliance with the network development and network composition requirements.

The Contractor shall contract its specialist and ancillary provider network prior to receiving enrollment. FSSA shall have the right to implement corrective actions and shall assess liquidated damages as described in Exhibit 2.B if the Contractor fails to meet and maintain the specialist and ancillary provider network access standards. FSSA's corrective actions may include, but are not limited to, withholding or suspending new member enrollment from the Contractor until the Contractor's specialist and ancillary provider network is in place. FSSA shall monitor the Contractor's specialist and ancillary provider network to confirm the Contractor is maintaining the required level of access to specialty care. FSSA shall have the right to increase the number or types of required specialty providers at any time.

5.1.1 Access to Culturally and Linguistically Competent Providers

To the extent possible, the Contractor shall provide members with access to providers who are culturally and linguistically competent in the language and culture of the member. For the purpose of this Contract, cultural and linguistic competence

includes providers who serve members of different races, ethnicities, color, national origins, sexes, sexual orientations, gender identity, abilities (including members with cognitive impairments, visual impairments, hearing impairment, and/or who use sign language or an alternative mode of communication), and those with limited English proficiency. The Contractor agrees to work toward increasing the provider pool of culturally and linguistically competent providers where there is an identified need, including but not limited to, participating in state efforts to increase the provider pool of culturally and linguistically competent providers, and participating in the state's needs assessment process and related planning effort to expand the pool.

The Contractor shall develop, implement, and monitor policies that require network providers to demonstrate that they are making necessary accommodations in providing services, employing appropriate language when referring to and talking with people with disabilities, and understanding communication, transportation, scheduling, structural, and attitudinal barriers to accessing services.

Nothing in this section shall obligate the Contractor to contract or continue to contract with a provider if the Contractor has determined that it has sufficient access for members to culturally and linguistically competent providers and/or if the provider does not meet the Contractor's participation criteria, including credentialing requirements.

5.2 Network Composition Requirements

In compliance with 42 CFR 438.207, 42 CFR 438.206(b)(1), and 42 CFR 438.206(b)(7), which provides assurances of adequate capacity and services, the Contractor shall:

- Serve the expected enrollment;
- Offer an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled;
- Maintain a sufficient number, mix and geographic distribution of providers to meet the needs of the anticipated number of enrollees in the service area per 42 CFR 438.207(b)(2) and as specified below;
- Maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities; and
- Demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services.

In compliance with 42 CFR 438.3(q)(1), 42 CFR 438.3(q)(3) and 42 CFR 438.3(r), the Contractor shall:

- Provide reasonable and adequate information, referral, and treatment for emergency medical conditions.
- Make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under the Contract can be furnished promptly and without compromising the quality of care.

In accordance with 42 CFR 438.207(b) - (c), 42 CFR 438.604(a)(5), 42 CFR 438.606 and

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42 CFR 438.206, in order for the State to certify that the Contractor meets the requirements for availability and accessibility of services, including the adequacy of the provider network, the Contractor shall submit initial and regular network access reports as directed by FSSA. Once the Contractor demonstrates compliance with FSSA's access standards, the Contractor shall submit network access reports on an annual basis and at any time there is a significant change to Contractor's operations and/or the provider network (i.e., the Contractor no longer meets the network access standards). The Contractor shall comply with the policies and procedures for network access reports set forth in HIP MCE Reporting Manuals. FSSA shall have the right to expand or revise the network requirements, as it deems appropriate.

The Contractor shall comply with the following, in accordance with 42 CFR 438.12 and 42 CFR 438.214(e):

- The Contractor shall not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification;

- If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This does not require the Contractor to contract with providers beyond the number necessary to serve the members' needs;

- The Contractor must comply with any additional provider selection requirements established by the State;

- The Contractor is not precluded from using different reimbursement amounts for different specialties or practitioners within the same specialty; and

- The Contractor is not precluded from establishing any measure designed to maintain quality and control costs consistent with the Contractor's responsibilities.

As required under 42 CFR 438.206(c)(1), the Contractor shall ensure that the network providers meet the State standards for timely access to care and services, taking into account the urgency of need for services. The Contractor must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members, if the Contractor also serves commercial members. The Contractor shall also make covered services available twenty-four (24)-hours-a-day, seven (7)- days-a-week, when medically necessary. In meeting these requirements, the Contractor shall:

- Establish mechanisms to ensure compliance by providers;
- Monitor providers regularly to determine compliance; and
- Take corrective action if there is a failure to comply.

The Contractor shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities per 42 CFR 438.206(c)(3).

The Contractor shall provide FSSA written notice at least ninety (90) calendar days in advance of the Contractor's inability to maintain a sufficient network in any county. FSSA shall have the right to expand or revise the network requirements, as it deems appropriate.

For purposes of the subsections below, "urban areas" are counties not designated by the Health Resources and Service Administration (HRSA) as a rural county. "Rural areas" are

those areas designated by HRSA as a rural county.

In addition to the specific Network Composition requirements listed below, the Contractor shall also meet or exceed the following:

- Contract with a minimum of 90% of IHCP enrolled acute care hospitals located in the State of Indiana.
- Contract with a minimum of 90% of IHCP enrolled Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) located in the State of Indiana.
- Contract with a minimum of 90% of IHCP enrolled Community Mental Health Centers (CMHC) located in the State of Indiana.
- Meet or exceed the following provider-to-member ratios:
    - 1:1,000 for PMPs (includes all physician and advanced practice nurses enrolled as a PMP with the Contractor)
    - 1:1,000 for Behavioral Health Providers (excluding physicians, CMHCs, and inpatient)
    - 1:2,000 for OB/GYNs
    - 1:2,000 for Dentists
    - 1:5,000 for Anesthesiology, Cardiology, Endocrinology, Gastroenterology, Nephrology, Ophthalmology, Orthopedic Surgery, General Surgery, Pulmonology, Rheumatology, Psychiatry, Urology, Infectious Disease, Otolaryngology, Oncology, Dermatology, and Physiatry/Rehabilitative

5.2.1 Acute Care Hospital Facilities

The Contractor shall provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. The transport distance to a hospital from the member's home shall be the usual and customary, not to exceed thirty (30) miles in urban areas and sixty (60) miles in rural areas. Exceptions shall be justified and documented to the State on the basis of community standards for accessing care. Inpatient services are covered when such services are prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

5.2.2 Primary Medical Providers (PMP)

A Primary Medical Provider (PMP), also known as a Primary Care Provider (PCP) or primary care doctor, is a primary care physician or other licensed health practitioner practicing in accordance with State law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. At a minimum, providers allowed to serve as PMPs must include physicians, physician assistants, and advanced practice registered nurses.

In general, primary care refers to all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed

practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them (see also: 42 CFR 438.2).

Providers may contract as a PMP with one or multiple MCEs. A PMP may also participate as a specialist in another MCE. The PMP may maintain a patient base of members (e.g., commercial, traditional Medicaid, HIP, Hoosier Healthwise or Hoosier Care Connect members). The Contractor shall not prevent the PMP from contracting with other MCEs.

The Contractor shall demonstrate compliance with 42 CFR 438.208. Specifically, the Contractor shall ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. PMPs must coordinate each member's physical and behavioral health care and make any referrals necessary. The Contractor shall ensure access to PMPs within at least thirty (30) miles of the member's residence. Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians, gynecologists and endocrinologists (if primarily engaged in internal medicine).

The Contractor shall assess the PMP's HIP practice when assessing the PMP's capacity to serve the Contractor's members.

The Contractor shall have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services twenty-four (24)-hours-a day, seven (7)-days-a-week and that PMPs have a mechanism in place to offer members direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number twenty-four (24)-hours-a-day, seven (7)-days-a-week. Each PMP shall be available to see members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations. The Contractor shall also assess the PMP's and HIP practice to ensure that the PMP's and HIP population is receiving accessible services on an equal basis with the PMP's and HIP population.

The Contractor shall ensure that the PMP provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The Contractor shall ensure that members have telephone access to their PMP (or appropriate designate such as a covering physician) in English and Spanish twenty-four (24)-hours-a-day, seven (7)-days-a-week.

The Contractor shall ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the IHCP Provider Manual. The Contractor shall monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

5.2.3 Specialist and Ancillary Providers

In addition to maintaining a network of PMPs, the Contractor shall provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers. A specialist is a doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

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As with PMPs, specialist and ancillary providers shall not be limited to serve in only one (1) MCE network. In addition, physicians contracted as a PMP (if applicable) with one (1) MCE may contract as a specialist with other MCEs.

The Contractor shall ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the IHCP Provider Manual. FSSA requires the Contractor to monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

FSSA requires the Contractor to develop and maintain a comprehensive network of specialty providers listed below. For providers identified with an asterisk (*), the Contractor shall provide, at a minimum, two providers of each specialty type within sixty (60) miles of the member's residence. For providers identified with two asterisks (**), the Contractor shall provide, at a minimum, one specialty provider within ninety (90) miles of the member's residence.

Specialties	Ancillary Providers
➢ Anesthesiologists* ➢ Cardiologists* ➢ Cardiothoracic surgeons** ➢ Dentists* ➢ Oral Surgeons * ➢ Dermatologists** ➢ Endocrinologists* ➢ Gastroenterologists* ➢ General surgeons* ➢ Hematologists* ➢ Infectious disease specialists** ➢ Interventional radiologists** ➢ Nephrologists* ➢ Neurologists* ➢ Neurosurgeons** ➢ Non-hospital based anesthesiologist (e.g., pain medicine)** ➢ OB/GYNs* ➢ Occupational therapists* ➢ Oncologists* ➢ Ophthalmologists* ➢ Optometrists* ➢ Orthodontists* ➢ Orthopedic surgeons* ➢ Otolaryngologists* ➢ Pathologists** ➢ Physical therapists* ➢ Psychiatrists* ➢ Pulmonologists* ➢ Radiation oncologists** ➢ Rheumatologists** ➢ Speech therapists* ➢ Urologists*	➢ Diagnostic testing* ➢ Durable Medical Equipment ➢ Home Health ➢ Prosthetic suppliers**

FSSA requires that the Contractor maintain different network access standards for the listed ancillary providers as follows:

- Two (2) durable medical equipment providers shall be available to provide services to the Contractor's members serving each county; and
- Two (2) home health providers shall be available to provide services to the Contractor's members serving each county.

Durable medical equipment includes purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicaid (see also: 42 CFR § 414.202).

In addition, the Contractor shall demonstrate the availability of providers with training, expertise and experience in providing tobacco dependence treatment services, especially to pregnant women. Evidence that providers are trained to provide tobacco dependence treatment services shall be available during FSSA's monthly onsite visits.

The Contractor shall contract with the Indiana Hemophilia and Thrombosis Center or a similar FSSA-approved, federally recognized hemophilia treatment center. This requirement is based on the findings of the Centers for Disease Control and Prevention (CDC) which illustrate that persons affected by a bleeding disorder receiving treatment from a federally recognized treatment center require fewer hospitalizations, experience less bleeding episodes and experience a forty percent (40%) reduction in morbidity and mortality.

The Contractor shall arrange for laboratory services only through those IHCP enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

5.2.4 Pharmacy Services

The Contractor shall establish a network of pharmacies. The Contractor or its Pharmacy Benefits Manager (PBM) shall provide at least two (2) pharmacy providers within thirty (30) miles or thirty (30) minutes from a member's residence serving each county, as well as at least two (2) durable medical equipment providers serving each county.

5.2.5 Non-Psychiatrist, Non-Substance Use Disorder (SUD) Behavioral Health Providers

In addition to the access requirements for psychiatrists as described in Section 5.2.3, the Contractor shall establish a network of behavioral health providers, addressing both mental health and addiction, including the following:

- Outpatient mental health and addiction clinics;
- Community mental health centers;
- Licensed clinical addiction counselors;
- Licensed psychologists;

- Health services providers in psychology (HSPPs);
- Licensed clinical social workers;
- Licensed independent practice school psychologists;
- Advanced practice nurses under IC 25-23-1-1(b), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center;
- Licensed marital and family therapists; and
- Licensed mental health counselors.

The Contractor is required to contract with Community Mental Health Centers (CMHCs) who are certified by the Division of Mental Health and Addiction (DMHA). If all CMHCs are not included in the provider network, the Contractor shall demonstrate that this does not prevent coordination of care with MRO and 1915(i) State Plan services as required in Sections 3.11.1 and 3.11.2. Further, as described in Section 3.7.4, the Contractor shall, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs, and shall provide physical health and other medical information to the appropriate CMHC for every member.

In urban areas, the Contractor shall provide at least one (1) behavioral health provider within thirty (30) minutes or thirty (30) miles from the member's home. In rural areas, the Contractor shall provide at least one (1) behavioral health provider within forty-five (45) minutes or forty-five (45) miles from the member's home. The Contractor shall provide assertive outreach to members in rural areas where behavioral health services may be less available and shall monitor utilization to assure equality of service access and availability.

All outpatient mental health services shall be delivered by licensed psychiatrists and HSPPs, or an advanced practice nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling.

5.2.6 Inpatient Psychiatric Facilities

The Contractor shall provide a sufficient number and geographic distribution of inpatient psychiatric facilities to serve the expected enrollment. The transport distance to an inpatient psychiatric facility from the member's home shall be the usual and customary, not to exceed sixty (60) miles. Exceptions shall be justified and documented to the State on the basis of community standards for accessing care.

5.2.7 SUD Providers

The Contractor shall establish a network of SUD treatment providers that provide the continuum of the American Society of Addiction Medicine (ASAM) levels of care. These providers should provide the following levels of treatment:

- Early intervention
- Outpatient
- Intensive outpatient
- Partial hospitalization
- Clinically-managed low-intensity residential
- Clinically managed high-intensity residential
- Medically-managed inpatient

The Contractor is encouraged to contract with all available SUD treatment providers. The Contractor must include a network of providers who are authorized to provide medication-assisted treatment (MAT), including buprenorphine.

The Contractor shall ensure the availability of a MAT provider within thirty (30) miles of the member's residence.

5.2.8 Dental Providers

The Contractor shall ensure the availability of a dentist practicing in general, family, and pediatric dentistry within thirty (30) miles of the member's residence. This can include dental providers who provide service within a federally qualified health center (FQHC). Specialty dentists such as orthodontists and dental surgeons shall be available within sixty (60) miles of the member's residence.

5.2.9 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Since Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are essential safety net providers, FSSA strongly encourages the Contractor to contract with FQHCs and RHCs that are willing to contract with the Contractor and meet all of the Contractor's requirements regarding the ability of these providers to provide quality services. The Contractor shall reimburse FQHCs and RHCs for services at no less than the level and amount of payment that the Contractor would make to a non-FQHC or non-RHC provider for the same services per section 1903(m)(2)(A)(ix) of the Social Security Act. In HIP, Contractors shall make covered services provided by FQHCs and RHCs available to members out-of-network if an FQHC or RHC is not available in the member's service area within the Contractor's network. In accordance with section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA) and 42 CFR 438.14(c)(1), the Contractor shall pay any out-of-network Indian healthcare provider (see Section 5.2.10) that is a FQHC for covered services provided to an American Indian/ Alaska Native member at a rate equal to the amount of payment that the Contractor would pay to an in-network FQHC that is not an Indian health care provider for the same services.

In accordance with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), FSSA shall make supplemental payments to FQHCs and RHCs that subcontract (directly or indirectly) with the Contractor. These supplemental payments represent the difference, if any, between the payment to which the FQHC or RHC would be entitled for covered services under the Medicaid provisions of BIPA and the payments made by the Contractor.

FSSA requires the Contractor to identify any performance incentives it offers to the FQHC or RHC. FSSA shall review and must approve any performance incentives. The Contractor shall report all such FQHC and RHC incentives which accrue during the Contract period related to the cost of providing FQHC-covered or RHC-covered services to its members along with any fee-for-service and/or capitation payments in the determination of the amount of direct reimbursement paid by the Contractor to the FQHC or RHC. If the incentives vary between the Contractor's and HIP lines of business, the Contractor shall so specify in its reporting to FSSA.

The Contractor shall perform quarterly claim reconciliation with each contracted FQHC or RHC to identify and resolve any billing issues that may impact the clinic's annual reconciliation conducted by FSSA.

Annually, FSSA requires the Contractor to provide the Contractor's utilization and

reimbursement data for each FQHC and RHC in each month of the reporting period. A separate report shall be provided for the Contractor's HIP lines of business. The report shall be completed in the form and manner set forth in HIP MCE Reporting Manuals. For HIP, the data shall be submitted on a paid claims basis.

The submitted FQHC and RHC data shall be accurate and complete. The Contractor shall pull the data by NPI or LPI, rather than other means, such as a Federal Tax ID number. The Contractor shall establish a process for validating the completeness and accuracy of the data, and a description of this process shall be available to FSSA upon request. The claims files should not omit claims for practitioners rendering services at the clinic nor should the files contain claims for practitioners who did not practice at the clinic.

In addition, FSSA requires the FQHC or RHC and the Contractor to maintain and submit records documenting the number and types of valid encounters provided to members each month. Capitated FQHCs and RHCs shall also submit encounter data (e.g., in the form of shadow claims to the Contractor) each month. The number of encounters will be subject to audit by FSSA or its representatives.

The Contractor shall work with each FQHC and RHC in assisting FSSA and/or its designee in the resolution of disputes concerning year-end reconciliations between the federally required interim payments (made by FSSA to each FQHC and RHC on the basis of provider reported encounter activity) and the final accounting that is based on the actual encounter data provided by the Contractor.

5.2.10 Indian Healthcare Providers

Section 5006 of ARRA and CFR provides certain protections for Indian health care providers in Medicaid. An Indian health care provider means a health care program, including providers of contract health services, operated by the Indian Health Service (IHS) or an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). The Contractor shall offer to enter into contracts with Indian health care providers participating in Medicaid that reflect the provisions in this Section.

5.2.10.1 Access to Indian Healthcare Providers

In accordance with section 5006(d) of ARRA, the Contractor shall:

- Permit any American Indian or Alaska Native (AI/AN) enrollee who is eligible to receive services from a participating Indian healthcare provider to choose to receive covered services from Indian healthcare providers in- and out-of-network per 42 CFR 438.14(b)(2), and if that Indian healthcare provider participates in the network as a PMP (if applicable), to choose that Indian healthcare provider as their PMP, as long as that Indian healthcare provider has the capacity to provide the services in accordance with 42 CFR 438.14(b)(3).

- Demonstrate that there are sufficient Indian healthcare providers in the Contractor's network to ensure timely access to services available under the Contract for AI/AN enrollees who are eligible to receive services from such providers per 42 CFR 438.14(b)(1) and 42 CFR 438.14(b)(5). The Contractor shall be held to standards issued by CMS regarding sufficiency of Indian healthcare providers

in states like Indiana where few Indian healthcare providers are available. In accordance with 42 CFR §438.56(c) and §457.1212, in the event that timely access to Indian healthcare providers in network cannot be guaranteed due to few or no network participating Indian healthcare providers, the sufficiency standard is satisfied if:

- AI/AN enrollees, living on or off tribal lands, are permitted by the Contractor, to access out-of-state Indian healthcare providers; or
- This circumstance is deemed a good cause reason under the managed care plan contract for AI/AN enrollees to disenroll from the managed care program into fee-for-service.

In accordance with 42 CFR §438.14(b)(3):

> The Contractor shall not require any service authorization or impose any condition for an AI/AN enrollee to access services at such facilities. This includes the right of the AI/AN enrollee to choose an Indian Healthcare Provider as a Primary Care Provider, if the Indian Healthcare Provider is a network Provider.

5.2.10.2 Referrals from Indian Healthcare Providers

When a physician in an Indian Healthcare facility refers an AI/AN enrollee to a Network Provider for services covered under this Contract, the Contractor shall not require the member to see a Primary Care Provider prior to the referral.

The network Provider to whom the Indian Healthcare physician refers the member may determine that services are not Medically Necessary or not covered.

5.2.10.3 Tribal Assessments and Care Plans

The Contractor will accept the results of home care service assessments, waiver assessments, reassessments and the resulting care plans developed by tribal assessors for AI/AN enrollees as determined by the tribe. Referrals to non-tribal providers for services resulting from the assessments must be made to providers within the Contractor's network. This applies to services requested by AI/AN enrollees residing on or off tribal land.

5.2.10.4 Tribal Training and Orientation

The Contractor shall provide training and orientation materials to tribal governments upon request and shall make available training and orientation for any interested tribal governments.

5.2.10.5 Payment for Indian Healthcare Providers

In accordance with section 5006(d) of ARRA, the Contractor shall:

- Reimburse Indian healthcare providers, whether in-or out-of-network, for covered services provided to AI/AN enrollees who are eligible to

receive services from such providers either at a rate negotiated between the Contractor and the Indian healthcare provider, or if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the services were provided by an in-network provider that is not an Indian healthcare provider in accordance with the requirements set out in section 1932(h) of the Social Security Act, 42 U.S.C. 1396u-2(h), 42 CFR 438.14(b)(2)(i)-(ii), and 42 CFR 438.14(c)(1)-(2). Non-FQHC Indian healthcare providers, whether in or out-of-network, have a right to receive the Encounter Rate established by the IHS on an annual basis and published in the Federal Register per 42 CFR 438.14(c)(2).

- Make prompt payment to all Indian healthcare providers as set forth in Section 8.5.3 and required by 42 CFR 438.14(b)(2)(iii), ARRA 5006(d), 42 CFR 447.45, and 42 CFR 447.46.

- Exempt from all cost sharing, including premiums and copayments, any AI/AN member who is eligible to receive or has received an item or service furnished by an IHCP or through referral under contract health services as required in 42 CFR 447.52(h), 42 CFR 447.56(a)(1)(x), and ARRA 5006(a).

- Not reduce payments to Indian healthcare providers, or other providers of contract health services under referral by an Indian healthcare provider, for covered services provided to an AI/AN enrollee by the amount of a copayment or other cost-sharing that would be due from the AI/AN enrollee if not otherwise prohibited under Section 5006(a) of ARRA.

- Permit all out-of-network Indian healthcare providers to refer eligible members to in network providers per 42 CFR 438.14(b)(6).

In accordance with 42 CFR 438.14(c)(3) and ARRA 5006(d), the State will provide a supplemental payment to non-FQHC Indian healthcare providers for covered services provided to AI/AN enrollees. The amount of the supplemental payment is the difference, if any, of the rate paid by the Contractor for the services and the rate that applies to the provision of such services under the State Plan, which is the encounter rate determined by IHS in the annual federal register notice. To the extent FSSA requires utilization and/or reimbursement data from the Contractor to make a supplemental payment to an Indian healthcare provider, the Contractor shall provide the requested data within thirty (30) calendar days of the request.

5.2.10.6 Cooperation

The Contractor agrees to work cooperatively with the State, other MCEs under contract with the State, and tribal governments to find mutually agreeable mechanisms to implement this section including, but not limited to, a common notification form by which tribal governments may report referrals to the Contractor.

5.2.11 County Health Departments

FSSA strongly encourages the Contractor to contract or enter into business

agreements with any health departments that are willing to coordinate with the Contractor and are able to meet the Contractor's credentialing and service delivery requirements.

5.2.12 Urgent Care Clinics

The Contractor shall affiliate or contract with any willing and able IHCP-enrolled urgent care clinics. The Contractor may utilize the taxonomy code 261QU0200X to help identify urgent care clinics but is not limited by this taxonomy code.

Per 42 CFR § 405.400, urgent care services means services furnished to an individual who requires services to be furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition.

5.2.13 Dialysis Treatment Center

The Contractor shall ensure the availability of one dialysis treatment center within sixty (60) miles of the member's residence.

5.2.14 OB/GYNs

The Contactor shall establish a network of OB/GYNs for women's healthcare and maternity needs. The Contractor shall ensure the availability of at least two OB/GYNs practicing within sixty (60) miles of the member's residence and at least one OB/GYNs practicing within thirty (30) miles of the member's residence. FSSA shall reserve the right to change this requirement at any time in accordance with Section 2.10.

5.2.15 Non-emergency Medical Transportation Providers

In accordance with 42 CFR 440.170(a)(4) the Contractor shall provide an appropriate means of NEMT for HIP Maternity and HIP State Plan individuals, who have no other means or transportation available, and addresses the safety needs of the person with disabilities and/or special needs.

5.3 Provider Enrollment and Disenrollment

The Contractor shall be responsible for meeting all provider screening and enrollment requirements described in 42 CFR 455 Subpart E.

The Contractor is prohibited from contracting with providers who have been or have had owners or operators (i.e., those with a controlling interest) excluded from the Federal Government or by the State's Medicaid program for fraud or abuse. The Contractor, as well as its subcontractors and providers, whether contract or non- contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any services provided by excluded individuals shall be refunded to and/or obtained by the State and/or the Contractor as prescribed in section 7.4 Program Integrity Overpayment Recovery. Where the excluded individual is the provider of services or an owner of the provider, all amounts paid to the provider for services rendered following their exclusion shall be refunded. The Contractor shall be responsible for checking the lists of providers currently excluded by the State and the Federal Government every thirty (30) calendar days.

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The Contractor shall capture ownership and control information from its providers required under 42 CFR 455 Subpart B. In addition, Contractor shall also maintain a list of all rendering providers of providers enrolled, even if rendering providers are not required to enroll with IHCP. Rendering providers are defined as those providers that are performing the services for which a provider bills the Contractor or IHCP. The Contractor shall also verify that all rendering providers are not currently excluded by the State and the Federal Government every thirty (30) calendar days. The federal list is available at: http://exclusions.oig.hhs.gov. FSSA reserves the right to immediately disenroll any provider if the provider becomes ineligible to participate in the IHCP. The Contractor shall immediately inform the OMPP PI Section via a written communication should it disenroll, terminate or deny provider enrollment or credentialing for "program integrity" reasons (i.e., the detection and investigation of fraud and abuse).

The Contractor shall follow established procedures to enroll and disenroll providers, including PMPs. The Contractor will provide training to call center care coordination and 24-hour nurse call line staff on locations and hours of urgent care clinics in the plan's network. The HIP MCE Policies and Procedures Manual provides detailed information on PMP and provider enrollment and disenrollment procedures.

To process provider enrollments and disenrollments with the Contractor, the Contractor shall submit the required information to the State fiscal agent through the Portal.

The Contractor shall report PMP disenrollments to the State fiscal agent's Provider Enrollment unit by mail, fax, e-mail or Portal. The Contractor shall first notify the State fiscal agent of the intent to disenroll a PMP within five (5) business days of the receipt/issuance of the PMP's disenrollment. The fiscal agent shall receive enrollment/disenrollment requests at least five (5) business days prior to the 24th day of the month before the date the Contractor desires the enrollment or disenrollment to become effective. As noted above, the OMPP PI Section should also receive disenrollment notices when they are program integrity related. When advanced notice is not feasible, including, but not limited to, in the event of provider death or exclusion due to fraud or abuse, the Contractor shall submit the disenrollment within five (5) business days of the provider's termination effective date. FSSA shall have the right to take corrective actions if the Contractor does not notify the State fiscal agent in a timely manner.

FSSA shall have the right to immediately disenroll any provider if the provider becomes ineligible to participate in IHCP.

When a PMP disenrolls from HIP, the Contractor shall be responsible for assisting members assigned to that PMP in selecting a new PMP within the Contractor's network. If the member does not select another PMP, the Contractor shall assign the member to another PMP in the Contractor's network before the original PMP's disenrollment is effective.

In accordance with 42 CFR 438.10(f), the Contractor shall make a good faith effort to provide written notice of a provider's disenrollment/termination to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis. Such notice shall be provided to members by the later of thirty (30) days prior to the effective date of the disenrollment/termination or within fifteen (15) calendar days of the Contractor's receipt or issuance of the provider disenrollment/termination notice. However, if the practice or practitioner notifies the Contractor less than 30 days prior to the effective date of the disenrollment/termination, the Contractor shall then notify members as soon as possible but no later than fifteen (15) calendar days after receipt of the notification from the practice or practitioner. If a PMP disenrolls from the HIP program, but remains an IHCP provider, the Contractor shall assure that the PMP provides continuation of care for and/or

HIP members for a minimum of thirty (30) calendar days or until the member's link to another PMP becomes effective.

The Contractor shall provide the IHCP MCE Practitioner Enrollment Form, IHCP MCE Hospital/Ancillary Provider Enrollment Form, or a Contractor specific Network Participation Request Form to providers to complete when requesting to join the Contractor's network. If a Contractor Network Participation Request Form is utilized, it shall include all the information captured on the IHCP MCE Enrollment Forms.

The Contractor shall follow the OMPP network effective date policy for all network participation requests. Providers will be effective with the Contractor on the first of the month following the receipt of a complete network participation request. The Contractor may allow for a brand-new provider to be effective the first of the month following the Contract execution. This effective date policy should be followed for all provider types. Providers must be fully enrolled and effective as an IHCP provider prior to becoming effective with the Contractor. The HIP MCE Policies and Procedures Manual provides detailed information on the provider effective date policy.

The Contractor shall have a central repository solution for all documentation and correspondence that is related to and occurs during the provider network participation process. MCEs must retain the request for participation form, all supporting documents submitted by the provider, all credentialing files, and contract related documents as well as written and email correspondence.

The Contractor shall conduct an annual internal review of the network participation process and determine if there are key inefficiencies that need to be addressed. This includes a review of all components of the provider network participation process and timeliness to complete provider requests.

5.4 Provider Agreements

The Contractor shall have a process in place to review and authorize all network provider contracts. The Contractor shall submit a model or sample contract of each type of provider agreement to FSSA for review and approval at least sixty (60) calendar days prior to the Contractor's intended use. The Contractor must notify FSSA of any changes to the sample contracts.

To allow sufficient processing time for the enrollment of the PMP and ensure an effective date of January 1, 2023, the Contractor shall submit the completed PMP enrollment request to the State fiscal agent through the Web Interchange-Provider Healthcare Portal by December 1, 2022.

The Contractor shall include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor shall identify and incorporate the applicable terms of its Contract with the State and any incorporated documents. Under the terms of the provider services agreement, the provider shall agree that the applicable terms and conditions set out in the Contract, any incorporated documents, and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members. The requirement set forth in Section 2.6 that subcontractors indemnify and hold harmless the State of Indiana do not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

In addition to the applicable requirements for subcontracts in Section 2.6, the provider agreements shall meet the following requirements:

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- Describe a written provider claim dispute resolution process.
- Require each provider to maintain a current IHCP provider agreement and to be duly licensed in accordance with the appropriate state licensing board and remain in good standing with said board.
- Require each provider to submit all claims that do not involve a third-party payer for services rendered to the Contractor's members ninety (90) calendar days or less from the date of service. The Contractor shall waive the timely filing requirement in the case of claims for members with retroactive coverage.
- The Contractor shall waive timely filing in cases where a retroactive coverage change or error has resulted in another MCE or Fee For Service recouping or recovering a claim. The Contractor shall permit the provider to submit a claim for payment within 90 days of claim's recovery or recoupment notice from the previous payer.
- Require each provider to utilize the Indiana Health Coverage Program Prior Authorization Request Form available on the Indiana Medicaid website for submission of prior authorization requests to the Contractor.
- Include a termination clause stipulating that the Contractor shall terminate its contractual relationship with the provider as soon as the Contractor has knowledge that the provider's license or IHCP provider agreement has terminated.
- Terminate the provider's agreement to serve the Contractor's HIP members at the end of the Contract with the State.
- Monitor providers and apply corrective actions for those who are out of compliance with FSSA's or the Contractor's standards.
- Obligate the terminating provider to submit all encounter claims for services rendered to the Contractor's members while serving as the Contractor's network provider and provide or reference the Contractor's technical specifications for the submission of such encounter data.
- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors.
- Provide the PMP with the option to terminate the agreement without cause with advance notice to the Contractor. Said advance notice shall not have to be more that ninety (90) calendar days.
- Provide a copy of a member's medical record at no charge upon reasonable request by the member, and facilitate the transfer of the member's medical record to another provider at the member's request.
- Require each provider to agree that it shall not seek payment from the State for any service rendered to a HIP member under the agreement.
- For behavioral health providers, require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven (7) calendar days from the date of the member's discharge.

- Require each provider to agree to use best commercial efforts to collect required copayments for services rendered to HIP Basic and HIP State Plan Basic members.

The Contractor shall have written policies and procedures for registering and responding to claims disputes for out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6-1.

The Contractor's in-network provider claim dispute process must adhere to the same rules laid out for out-of-network providers in 405 IAC 1-1.6-1

In accordance with 42 CFR 438.60, no payments should be made to a network provider other than by the Contractor for services covered under the Contract with the State, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR chapter IV.

5.5 Provider Credentialing

The Contractor's network of providers must be credentialed as required under 42 CFR 438.214(b) and 42 CFR 438.206(b)(6). In all contracts with network providers, the Contractor must follow a documented process and the State's uniform credentialing and re-credentialing policy, as appropriate per 42 CFR 438.12(a)(2) and 42 CFR 438.214(b). The Contractor shall have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current state licensure and enrollment in the IHCP. The Contractor's credentialing and re-credentialing process for all contracted providers shall meet the National Committee for Quality Assurance (NCQA) guidelines. The same provider credentialing standards shall apply across all Indiana Medicaid programs.

The Contractor shall use the information outlined on IHCP MCE Practitioner Enrollment Form and IHCP MCE Hospital/Ancillary Provider Enrollment Forms during the credentialing process. The Contractor shall ensure that providers agree to meet all of FSSA's and the Contractor's standards for credentialing PMPs and specialists, and maintain IHCP manual standards, including:

- Compliance with state record keeping requirements;
- FSSA's access and availability standards; and
- Other quality improvement program standards.

As provided in 42 CFR 438.214(c) and 42 CFR 438.12(a), which prevents discrimination in provider selection, the Contractor's provider credentialing and selection policies shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor shall not employ or contract with providers that have been excluded from participating in federal health care programs under section 1128 or section 1128A of the Social Security Act per 42 CFR 438.214(d)(1). The Contractor shall notify FSSA, in the manner prescribed by the State, of any credentialing applications that are denied due to program integrity related reasons.

The Contractor shall process all credentialing applications within thirty (30) calendar days of receipt of a complete application. If the Contractor delegates credentialing functions to a delegated credentialing agency, the Contractor shall ensure all credentialed providers are loaded into the Contractor's provider files and claims system within seven (7) calendar days of receipt from the delegated entity.

The Contractor shall outline for providers the information necessary and steps required to

be credentialed with the Contractor, including what provider types require credentialing and which do not. This information should be communicated on the Contractor's public facing website and in direct correspondence with providers.

The contractors credentialing and re-credentialing process, policies and procedures must be demonstrated in readiness review.

The State intends to implement a centralized model for provider enrollment and credentialing. Upon implementation the Contractor shall accept the FSSA enrollment and credentialing determinations as final. The Contractor shall not require providers to submit supplemental information for purposes of conducting an additional credentialing process. Contractor may not add credentialing requirements to the contracting process, or delay contracting with a provider consistent with IC 12-15-11-9(b). The Contractor shall continue to retain final decision-making responsibilities with respect to provider contracts and network design, subject to other requirements of this Contract including but not limited to network adequacy. The Contractor shall comply with all rules, regulations, and policies established.

5.6 Medical Records

The Contractor shall ensure that providers maintain and share member health records in accordance with professional standards per 42 CFR 438.208(b)(5). The Contractor shall assure that its records and those of its participating providers document all medical services that the member receives in accordance with state and federal law. In accordance with 405 IAC 1-1.4-2, the provider's medical record shall include, at a minimum:

- The identity of the individual to whom service was rendered;
- The identity of the provider rendering the service;
- The identity, including date signature or initials, and position of the provider employee rendering the service, if applicable;
- The date on which the service was rendered;
- The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only;
- A detailed statement describing services rendered, including duration of services rendered;
- The location at which services were rendered;
- The amount claimed through Medicaid for each specific service rendered;
- Written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document the acute medical needs;
- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment and ongoing evaluations as to assess progress and refine goals; and
- X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imaging records.

The medical records should include details such as prescriptions for medications; inpatient discharge summaries; patient histories (including immunizations) and physicals; a list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs; and a record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and x-ray tests and findings.

The Contractor's providers shall maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records shall be legible, signed and dated and maintained for at least seven (7) years as required by state and federal regulations.

The Contractor's providers shall provide a copy of a member's medical record upon reasonable request by the member at no charge, and the provider shall facilitate the transfer of the member's medical record to another provider at the member's request.

Confidentiality of, and access to, medical records shall be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal requirements, including, but not limited to, 42 CFR Part 2 specific to confidentiality of alcohol and drug abuse records.

The Contractor's providers shall permit the Contractor and representatives of FSSA to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason, in accordance with 405 IAC 1-1.4-2. The failure of Contractor and/or its participating providers to keep and maintain detailed and accurate medical records as required in this section may result in Contractor and/or its participating providers repaying FSSA for amounts paid corresponding to services rendered for which accurate and detailed medical records are not timely provided.

Records must be provided by Contractor and/or its participating providers upon request within the timeframe identified in the request. FSSA in its sole discretion may authorize additional time for responding to medical records requests made by Contractor or FSSA. The failure of Contractor and/or its participating providers to timely submit records may result in the assessment of an overpayment and/or other non-compliance remedies identified in Exhibit 2.B. FSSA encourages Contractors to use technology, including the participation in health information exchanges, where appropriate to transmit and store medical record data. See Section 8.8 for more information regarding electronic health records and data sharing requirements.

5.7 Provider Education and Outreach

The Contractor shall provide ongoing education to its provider network on the Hoosier Healthwise and HIP program, as well as Contractor-specific policies and procedures. In addition to developing its own provider education and outreach materials, the Contractor shall be required to coordinate with FSSA-sponsored provider outreach activities upon request.

The contractor shall provide a provider relations plan to include frequency of visits and outcomes from concerns identified, program education, claim issues, etc.

The Contractor shall educate its contracted providers, including behavioral health providers, regarding provider requirements and responsibilities, the Contractor's prior authorization policies and procedures, clinical protocols, member's rights and responsibilities, claims submission process, claims dispute resolution process, program

integrity, identifying potential fraud and abuse, pay-for-performance programs and any other information relevant to improving the services provided to the HIP members.

5.7.1 Provider Communications Review and Approval

All provider communication materials required in this section or otherwise developed by the Contractor shall be pre-approved by FSSA. The Contractor shall develop and include a Contractor-designated inventory control number on all provider communications, including letters, forms, bulletins and promotional, educational, training, informational or other outreach materials, with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate FSSA's review and approval of all provider communications and documentation of its receipt and approval of original and revised documents.

The Contractor shall submit all provider communication materials designed for distribution to, or use by, contracted providers to FSSA for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor shall also submit any material changes to previously approved provider communication materials to FSSA for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor shall receive approval from FSSA prior to distribution or use of materials. FSSA's decision regarding any communication materials is final. The Contractor shall include the State program logo(s) in their provider communication materials upon FSSA request.

The Contractor shall not refer to or use the FSSA, OMPP, or other State agency name or logo in its provider communications without prior written approval. The Contractor shall request in writing approval from FSSA for each desired reference or use at least thirty (30) calendar days prior to the reference or use. Any approval given for the FSSA, OMPP or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval.

All FSSA-approved provider communication materials shall be available on the Contractor's provider website within three (3) business days of distribution. The provider communication materials shall be organized online in a user-friendly, searchable format by communication type and subject.

Any provider communications by a subcontractor to IHCP providers regarding the HIP program must comply with the provisions in the section, just as the contractor is required.

5.7.2 Provider Policy and Procedures Manual

The Contractor shall provide and maintain a Provider Policies and Procedures Manual for use by the Contractor's network of HIP providers. The Provider Policies and Procedures Manual shall be available both electronically and in hard copy (upon request) to all network providers, without cost, at the time the contract is initiated, when there are any chances in policies and procedures, and upon a provider's request. The Provider Policies and Procedures Manual shall include, at minimum, the following information, separately stated for each State lines of business as appropriate:

- Benefits and limitations;
- Claims filing instructions;

- Criteria and process to use when requesting prior authorizations;
- Definition and requirements pertaining to urgent and emergent care;
- Participants' rights;
- Providers' rights for advising or advocating on behalf of his or her patient;
- Provider non-discrimination information;
- Procedures for a provider to report when an overpayment is received, how to return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment per 42 CFR 438.608(d)(2);
- Policies and procedures for member grievance, appeal, and fair hearings, availability of member assistance, and the member's right to request continuation of benefits, in accordance with 42 CFR 438.414, 42 CFR 438 Subpart F, and 42 CFR 438.10(g)(2)(xi);
- Frequently asked questions and answers; and
- Contractor, FSSA and OMPP contact information such as addresses and phone numbers.

The Contractor shall offer Provider Policies and Procedures Manual training to all network providers when they are initially enrolled in the network, whenever there are changes in policies or procedures, and upon a provider's request. Updates or changes in operation that require revisions to the Provider Policies and Procedures Manual shall be submitted to FSSA for review and approval in accordance with the requirements outlined in Section 5.7.1.

5.7.3 Education for HIP Providers

For HIP providers, the Contractor shall provide education and outreach about the SUPDL and nonformulary drug coverage for HIP State Plan, HIP Plus, and HIP Basic benefits; medically frail policies and procedures; POWER Accounts, including preventive care and rollover; co-payments for emergency room services; co-payments for HIP Basic and HIP State Plan Basic services; and the POWER Account and payment procedures.

The Contractor shall also educate its HIP providers about its pregnancy-related services and policies. Such education shall emphasize that members will transition to the HIP Maternity (MAMA) benefit plan.

Provider education shall also include information about member cost-sharing, including the five percent (5%) cap on cost-sharing, and the requirement that providers reduce or waive member co-payments if notified by the Contractor or the State that the member's family has exceeded the five percent (5%) cap on member cost-sharing. Any notification to providers shall identify the time period during which the co-payments shall be reduced or waived.

5.8 Contractor Communications with Providers

The Contractor shall have in place policies and procedures to maintain frequent

communications and provide information to its provider network. As required by 42 CFR 438.207(c), which sets notification requirements, the Contractor shall notify FSSA of material changes, as described in Section 2.9, that may affect provider procedures at least thirty (30) calendar days prior to notifying its provider network of the changes. The Contractor shall give providers at least forty-five (45) calendar days advance notice of material changes that may affect the providers' procedures such as changes in subcontractors, claims submission procedures or prior authorization policies. The Contractor shall post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

All public facing communications from the Contractor's subcontractors must be approved by FSSA and meet the same timeframe as the contractor's requirement.

Because some pharmacy services are covered by Indiana Medicaid FFS under the pharmacy benefit consolidation, Contractors shall educate providers about which pharmacy services should be submitted to the State fiscal agent for reimbursement, and which should be submitted to the Contractor. The Contractor shall also ensure that providers receive education about the SUPDL and nonformulary drug coverage for HIP State Plan, HIP Plus, and HIP Basic benefits.

In accordance with 42 CFR 438.102, which relates to provider-enrollee communications, the Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member. Contractor shall communicate this clearly to all providers.

5.8.1 Provider Website

The Contractor shall develop and maintain a website in an FSSA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines for network and out-of-network providers. The website shall be live and meet the requirements of this section on the effective date of the Contract. FSSA shall pre-approve the Contractor's website information and graphic presentations. The Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website described in Section 4.4.3.

To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor shall date each web page, change the date with each revision and allow users print access to the information. The provider website may have secured information available to network providers but shall, at a minimum, have the following information available to all providers:

- Contractor's contact information;
- Provider Policy and Procedure Manual and associated forms;
- All of Contractor's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic;
- Claim submission information including, but not limited to the Contractor submission and processing requirements, paper and electronic submission procedures, emergency room auto-pay lists and frequently asked questions;

- Provider claims dispute resolution procedures for contracted and out-of-network providers;
- Prior authorization procedures, including a complete list of services which require prior authorization;
- Appeal procedures;
- Entire network provider listings;
- Links to FSSA and OMPP websites for general Medicaid and HIP information;
- HIPAA and 42 CFR Part 2 Privacy Policy and Procedures; and
- Network participation request information including all of the information, steps, and forms that are required from the provider for a request to join the Contractor's network and be credentialed.

Upon identification of a system configuration error involving provider enrollment, prior authorization, or claims processing that impacts the ability to correctly pay claims, the Contractor shall post a formal notification on its website with the following information:

- The date(s) of service of claims impacted
- A brief explanation of the provider enrollment, prior authorization, or claims processing error
- The timeframe for the system correction to be made
- The method by which impacted claims will be corrected

5.8.2 Provider Services Helpline

The Contractor shall maintain a toll-free telephone helpline for all providers with questions, concerns or complaints. With the exception of the holidays listed below, the Contractor shall staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a twelve (12)-hour business day, from 8 a.m. to 8 p.m. Eastern, Monday through Friday. The provider helpline may be closed on the following holidays: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas. The helpline shall open sixty (60) days prior to the Contractor's go live date, subject to State approval. The helpline staff must be based in Indiana and take at a minimum seventy percent (70%) of the health plan's calls, except when emergency rollover is required. The State must be notified if such an emergency is taking place. A minimum of fifty percent (50%) of helpline staff must be employees of the prime Contractor.

The Contractor may request that additional days, such as the day after Thanksgiving, be authorized for limited staff attendance. This request shall be submitted to FSSA at least thirty (30) calendar days in advance of the date being requested for limited staff attendance and must be approved by FSSA. For all days with a closure, early closing or limited staff attendance, there shall be a process for providers to process

emergency prior authorizations as needed. Call center closures, limited staffing or early closures shall not burden a member's access to care.

The Contractor shall maintain a system for tracking and reporting the number and type of provider calls and inquiries. The Contractor shall monitor its provider helpline and report its telephone service performance to FSSA each quarter as described in the HIP MCE Reporting Manuals.

5.8.3 IHCP Workshops and Seminars

The State fiscal agent sponsors workshops and seminars for all IHCP providers. The Contractor shall participate in the workshops and attend the provider seminars. A Contractor representative shall be available to make formal presentations and respond to questions during the scheduled time(s). The Contractor is also encouraged to set up an information booth with a representative available during the provider seminars.

5.8.4 Provider Welcome Letter

The Contractor is required to send out a provider welcome letter within five (5) business days of the network participation process completion. The Contractor shall include the standard language provided by OMPP in all provider welcome letters. The standard language includes things such as network effective date, effective date policy, and reference to provider materials. The Contractor may add additional language at the discretion of and approval by OMPP.

The welcome letter should be the final confirmation that the provider is fully enrolled in the Contractor's network and able to render services.

5.9 Payment for Health Care-Acquired Conditions and Provider-Preventable Conditions

The Contractor shall develop policies and procedures to prohibit the payment of charges for certain hospital acquired conditions and "never events." These policies and procedures shall be approved by FSSA prior to implementation and upon any subsequent change.

In accordance with 42 CFR 434.6(a)(12)(i), 42 CFR 438.3(g) and 42 CFR 447.26(b) no payment shall be made by the Contractor to a provider for a provider-preventable condition as identified in the State Plan when the following criteria are met:

- Is found by the State or Contractor, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
- Has a negative consequence for the beneficiary.
- Is auditable.
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

All payments made by Contractor for "never events" shall be recovered by the Contractor and/or FSSA as prescribed in Section 7.4 Program Integrity Overpayment Recovery. The

Contractor shall report all identified provider-preventable conditions, as required by FSSA per 42 CFR 438.3(g).

The Contractor's policies on non-payment of certain hospital-acquired conditions shall comply with 405 IAC 1-10.5-5 and the IHCP Provider Bulletin regarding Present on Admission Indicator for Hospital Acquired Conditions dated March 30, 2023, (BT202326), as well as any updates or amendments thereto. IHCP follows the CMS determinations for hospital-acquired conditions (HACs) that will not be considered for payment if the diagnoses were not present on admission (POA).

The Contractor shall require that as a condition of payment, all providers agree to comply with the reporting requirements in 42 CFR 447.26(d), 42 CFR 438.3(g), and 42 CFR 434.6(a)(12)(ii). The Contractor's policy on non-payment of certain never events shall be developed in accordance with current Medicare National Coverage Determinations (NCDs), as well as any Indiana Medicaid FFS rules or other guidance adopted or issued by FSSA at a future date.

5.10 Member Payment Liability

In accordance with 42 CFR 438.106, 42 CFR 438.3(k), 42 CFR 438.230, and section 1932(b)(1)-(2) and (6) of the Social Security Act, which relates to liability for payment, the Contractor and its subcontractors shall provide that members are not held liable for any of the following:

- Any payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly;
- Covered services provided to the member for which FSSA does not pay the Contractor;
- Covered services provided to the member for which FSSA or the Contractor does not pay the provider that furnishes the services under a contractual, referral or other arrangement; and
- The Contractor's debts or subcontractor's debts, in the event of the entity's insolvency.

If the Contractor imposes premiums or charges on enrollees that are in excess of those permitted in the Medicaid program, in accordance with 42 CFR 438.700(b)(2), the State may impose a civil monetary penalty of up to twenty-five thousand dollars ($25,000) or double the amount of the excess charges (whichever is greater) and may enforce other corrective actions as described in Exhibit 2.B. Per 42 CFR § 447.51, premium means any enrollment fee, premium, or other similar charge.

If the State imposes a civil monetary penalty on the Contractor for this violation, the State will deduct the amount of the overcharge from the penalty and return it to the affected enrollee per 42 CFR 438.704(c).

The Contractor shall ensure that its providers do not balance bill its members, i.e., charge the member for covered services above the amount paid to the provider by the Contractor per CFR 438.3(k), 42 CFR 438.230(c)(1)-(2), and section 1932(b)(6) of the Social Security Act. If the Contractor is aware that an out-of-network, non-IHCP provider, such as an out-of-state emergency services provider, is balance billing a member, the Contractor shall instruct the provider to stop billing the member and to enroll in the IHCP

in order to receive reimbursement from the Contractor. The Contractor shall also contact the member to help resolve issues related to the billing.

IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered IHCP service. Provider acceptance of payment from the Contractor as payment in full is a condition of participation in the IHCP. An IHCP provider can bill a member only when the following conditions have been met:

- The service rendered must be determined to be non-covered by the IHCP;
- The member has exceeded the program limitations for a particular service;
- The member must understand, before receiving the service, that the service is not covered under the IHCP, and that the member is responsible for the charges associated with the service; and
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service. See the IHCP Provider Manual for more information.

In cases where prior authorization is denied, a provider can bill a member for covered services if certain safeguards are in place and followed by the provider. The Contractor shall establish, communicate and monitor compliance with these procedures, which shall include at least the following:

- The provider must establish that authorization has been requested and denied prior to rendering the service;
- The provider has an opportunity to request review of the authorization decision by the Contractor. The Contractor must inform providers of the contact person, the means for contact, the information required to complete the review and the procedures for expedited review if necessary;
- If the Contractor maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that authorization has been denied—if the provider is an out-of-network provider, the provider must also explain that covered services may be available without cost in-network if authorization is provided;
- The member must be informed of the right to contact the Contractor to file an appeal if the member disagrees with the decision to deny authorization;
- The provider must inform the member of member responsibility for payment if the member chooses to or insists on receiving the services without authorization;
- If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver shall meet the following requirements:
    - The waiver is signed only after the member receives the appropriate notification;
    - The waiver does not contain any language or condition to the

effect that if authorization is denied, the member is responsible for payment;

- Providers must not use non-specific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services;

- The waiver must specify the date the services are provided and the services that fall under the waiver's application; and

- The provider must have the right to appeal any denial of payment by the Contractor for denial of authorization.

This section should not be interpreted as interfering with a provider's ability to hold HIP members liable for the emergency services co-payment or HIP Basic or HIP State Plan Basic member liability for allowable copayment amounts set forth in Sections 13.1.1 and 13.1.2.

Further, this section should not be interpreted as preventing payment of covered services with POWER Account funds before the member's deductible has been met. However, if the Contractor permits providers to bill members for services that require authorization, but for which authorization is denied, as outlined above, POWER Account funds shall not be used to reimburse the provider for the non-covered service.

5.11 Provider Directory

The Contractor shall develop a searchable provider directory. A printed copy of the provider directory shall also be available to members and FSSA upon request. The Contractor may use the same provider directory for its Indiana State Medicaid lines of business as long as the directory clearly designates which population(s) the provider serves.

In accordance with 42 CFR 438.10(h), the provider directory shall include the following information for all network providers, including but not limited to, all types of PMPs, specialists, hospitals, pharmacies, and behavioral health providers:

- Names and group affiliations of PMPs, the PMPs' service locations (including county), phone numbers, office hours, type of PMP (i.e., family practice, general practitioners, general internists, general pediatricians, obstetricians and gynecologists, and internal medicine physicians specializing in pediatrics or endocrinology) and whether the PMPs are accepting new members;

- Names and group affiliations of specialty providers (including behavioral health providers and community mental health centers, and medication assistance treatment [MAT] providers), their service locations (including county), phone numbers, office hours, type of specialty;

- Lists of hospital providers, pharmacies, behavioral health providers, home care providers and all other network providers;

- Lists of in-network pharmacies serving HIP members, their service locations, and phone numbers;

- Cultural and linguistic capabilities, including languages (including ASL) spoken by the provider or the provider's office personnel (including skilled medical interpreters, if applicable);

- Whether the provider has completed cultural competence training;
- Provider websites, if applicable;
- If the provider has accommodations for people with physical disabilities, including offices, exam rooms, and equipment;
- Pharmacies and behavioral health providers; and
- Contact information for all brokers contracted with the MCE and identification of providers that are not accepting new patients.

The Contractor shall include the aforementioned provider network information in an FSSA-approved format (compliant with Section 508 of the US Rehabilitation Act) on its member website. The Contractor shall list provider network information by county on the Contractor's website and update the information every two (2) weeks. As required by 42 CFR 438.10(h)(3)(ii), provider network information on the Contractor's website must be updated no later than thirty (30) calendar days after the Contractor receives updated provider information. Network provider information shall be available to print from a remote user location and in a machine-readable file and format as specified by the Secretary per 42 CFR 457.1207 and 42 CFR 438.10(h)(4). Paper provider network directories must be updated at least monthly if the Contractor does not have a mobile-enabled, electronic directory; or quarterly if the Contractor has a mobile-enabled electronic directory (42 CFR 438.10(h)(3)).

5.12 Hospital Assessment Fee

Hospital Assessment Fee (HAF) payments will be integrated into capitation rates. This is a State-directed minimum fee schedule payment, as described in 42 CFR 438.6(c)(1)(iii)(A); the Contractor shall pay no less than State plan approved enhanced reimbursement to eligible providers. Contractors are required to pay HAF hospitals at the enhanced Medicaid rates for HAF eligible services detailed below:

- HAF eligible hospitals
    - Contracted and Non-Contracted providers: MCEs shall pay one hundred percent (100%) of the enhanced (HAF) rates, which is one hundred percent (100%) of the Medicaid fee schedule rate multiplied by the HAF factor OR one hundred percent (100%) of the Medicaid Inpatient APR DRG rate multiplied by the HAF factor.
- Non-HAF eligible hospitals and facilities
    - Contracted providers: MCEs shall pay one hundred percent (100%) of the Medicare rate or one hundred and thirty percent (130%) of the Medicaid rate when no Medicare rate exists through 12/31/24. Effective 1/1/25, MCEs shall pay the minimum fee schedule.
    - Non-contracted providers: MCEs shall pay according to administrative code 405 IAC 10-9-4 (b) and State statute IC 12-15-44.5-5.

5.13 Physician Faculty Access to Care (PFAC) Program

Enhanced reimbursement is authorized under the Indiana Physician Faculty Access to Care (PFAC) program. This is a State-directed minimum fee schedule payment, as described in 42 CFR 438.6(c)(1)(iii)(A); the Contractor shall pay no less than State plan approved enhanced reimbursement to eligible providers.

The program provides enhanced reimbursement for physician services rendered to all of the non-dual Medicaid populations, including those served under risk-based managed care programs, by qualified faculty physicians or other eligible practitioners, as defined in the State Plan.

Eligible physicians and practitioners must be employed by either Indiana University Health, Inc. (IU Health Physicians) or the Sidney and Lois Eskenazi Hospital (Eskenazi Medical Group), also known as the Health and Hospital Corporation of Marion County. The physicians must be affiliated with an in-state medical school, licensed by the State of Indiana, and enrolled as an Indiana Medicaid provider. The program also applies to non-physician staff such as nurses, physician assistants, midwifes, social workers, psychologists, and optometrists.

Eligible physicians and non-physician staff are eligible for reimbursement at up to the average commercial rate (ACR), with actual enhanced reimbursement subject to annual performance on specified access metrics. Performance payout levels are calculated separately for IU Health Physicians and Eskenazi Medical Group, respectively.

Contractor is responsible for ensuring PFAC payments are delivered to eligible providers.

5.14 State-directed Applied Behavioral Analysis (ABA) Reimbursement

The Contractor shall pay for Applied Behavioral Analysis (ABA) services at no less than the State plan approved fee schedule, and will update provider reimbursement in coordination with updates to State plan approved rates. This is a State-directed minimum fee schedule payment, as described in 42 CFR 438.6(c)(1)(iii)(A).

ABA services include procedure codes 97151 through 97158, 0362T, and 0373T.

5.15 Reimbursement for Nursing Facilities

Contractors shall pay Nursing Facilities at a rate not less than the minimum fee schedule established by the State beginning January 1, 2024.

6.0 Quality Assessment and Performance Improvement / Utilization Management

The Contractor shall monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members in the HIP program by all providers in all types of settings, in accordance with the provisions set forth in this Scope of Work. In compliance with state and federal regulations, the Contractor shall submit quality improvement data, including data that meets HEDIS standards for reporting and measuring outcomes, to FSSA that includes the status and results of performance improvement projects. Additionally, the Contractor shall submit information requested by FSSA to complete the State's annual Quality Strategy Plan for CMS.

6.1 Quality Assessment and Performance Improvement Program

The Contractor's Medical Director shall be responsible for the coordination and

implementation of the Quality Management and Improvement Program. The program shall be based on professional standards; the purpose of the program is to assess and monitor the health care services provided to the members enrolled in the organization per IC 27-13-6-1(a); establish procedures that assess the availability, accessibility, and continuity of care of services as well as implement any corrective actions if necessary per IC 27-13-6-1(b). The State will identify certain performance measurements that will be outlined in the Quality Strategy Plan including those specified by CMS [42 CFR 438.330(c)(1)(i))].

The Contractor is expected to measure and report data to the State on its performance measures based on the frequency set forth in the MCE Reporting Manual or as requested by the State [42 CFR 438.330(c)(2)] as a means to monitor and evaluate quality performance of the program. Specifically, the Contractor is required to provide HEDIS and CAHPS data per MCE Reporting Manual.

The program shall have objectives that are measurable, realistic and supported by consensus among the Contractor's medical and quality improvement staff. Through the Quality Management and Improvement Program, the Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services to members in accordance with 42 CFR 438.330(a)(1). As a key component of its Quality Management and Improvement Program, the Contractor shall develop incentive programs for both providers and members, with the ultimate goal of encouraging appropriate utilization of health care resources and improving health outcomes of HIP members. The Contractor may establish different provider and member incentives for its HIP populations.

The State requires that the Quality Assessment and Performance Improvement Program at a minimum must include according to IC 27-13-6-3:

(1) A written statement of the scope and purpose of the quality management program, including a written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to its members. This may be included as part of the Quality Assessment and Performance Improvement Program Description. The statement must describe quality improvement activities including the following per IC 27-13-6-4:

- Problem assessment, identification, selection, and study.
- Corrective action, monitoring, evaluation, and reassessment.
- Interpretation and analysis of patterns of care rendered to individual patients by individual providers.
- Comparison between patterns of care, including outcomes, rendered to patients by providers and the cost to the health maintenance organization of that care.
- A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation, and report format.

(2) The organizational structure responsible for quality management activities.

(3) Any contractual arrangements, when appropriate, for delegation of quality management activities.

(4) Confidentiality of policies and procedures.

(5) A system of ongoing evaluation activities.

(6) A system of focused evaluation activities.

(7) A system for credentialing providers and performing peer review activities.

(8) Duties and responsibilities of the designated physician responsible for the quality management activities.

In addition, the State requires the Contractor's QAPI program to have mechanisms in place that evaluate the health care services provided by primary care and specialist physicians and those provided by ancillary and preventive health care services across all care settings (IC 27-13-6-2).

It is also the responsibility of the Contractor to have procedures in place to monitor and act on quality opportunities including corrective action, if appropriate, for health care services provided that do not meet standards of care. There must be written plans in place that address appropriate action to take when it is determined that inappropriate or substandard services have been provided or when there were services that should have been provided were not provided (IC 27-13-6-5).

According to IC 27-13-6-6, the Contractor shall utilize and maintain member record systems to facilitate documentation and retrieval of clinical information for the purpose of evaluating care coordination as well as assess the quality of health and medical care being provided.

The Contractor shall also include Performance Improvement Projects (PIPs), including any required by the State or CMS, that focus on clinical and non-clinical areas in compliance with 42 CFR 438.330(a)(2), 42 CFR 438.330(b), and 42 CFR 438.330(d)(1)-(3). Each PIP shall include:

- A design to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction;
- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- An evaluation of the effectiveness of the interventions based on the performance measures collected as part of the QIP; and
- Planning and initiation of activities for increasing or sustaining improvement.

The Contractor shall report the status and results of each performance improvement project to the state as required in the MCE Reporting Manual.

As a part of the Contractor's Quality Management and Improvement Program, the Contractor shall participate in FSSA's annual performance improvement program.

The Contractor shall meet the requirements of 42 CFR 438 subpart E on Quality Assessment and Performance Improvement and the National Committee for Quality Assurance (NCQA), including but not limited to the requirements listed below, in developing its Quality Assessment and Performance Improvement Program and the Quality Management and Improvement Program Work Plan. In doing so, it shall include (i) an assessment of quality and appropriateness of care provided to members with special needs, including all medically frail HIP members; (ii) complete performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects; and (iii) produce quality of care reports at least annually.

EXHIBIT 1B

SCOPE OF WORK – HEALTHY INDIANA PLAN

The Contractor's Quality Management and Improvement Program shall comply with 42 CFR 438.330(a)(2), 42 CFR 438.330(b), 42 CFR 438.330(c), and 42 CFR 438.340 and include the following:

- Include developing and maintaining an annual Quality Management and Improvement Program Work Plan which sets goals, establishes specific objectives, identifies the strategies and activities to undertake, monitors results and assesses progress toward the goals.

- Have in effect mechanisms to detect both underutilization and overutilization of services. The activities the Contractor takes to address underutilization and overutilization must be documented.

- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.

- Incorporate an internal system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of quality and appropriateness of care furnished to special needs populations and other quality improvement activities requested by FSSA.

- Participate appropriately in clinical studies, and use Healthcare Effectiveness Data and Information Set ® (HEDIS®) rate data and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members. In assessing the quality and appropriateness of care provided to members under 21 years of age, the Contractor must act in accordance with EPSDT requirements.

- Collect measurement indicator data related to areas of clinical priority and quality of care. FSSA will establish areas of clinical priority and indicators of care. FSSA reserves the right to identify additional conditions at any time, as the areas reflect the needs of the Indiana Medicaid populations. These areas may vary from one year to the next and from program to program. Examples of areas of clinical priority include:

    - HIV and Hepatitis C care
    - Behavioral health and physical health care coordination;
    - Immunization rates;
    - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
    - Prenatal care;
    - Postpartum care;
    - Emergency room utilization;
    - Access to care;
    - Special needs care coordination and utilization;
    - Asthma;
    - Obesity,
    - Tobacco dependence treatment, especially for pregnant women;
    - Inpatient and emergency department follow-up;
    - Timely follow-up and notification of results from preventive care; and
    - Integrated medical and behavioral health utilization.

- Report any national performance measures developed by CMS in the future. The Contractor must develop an approach for meeting the desired performance levels

established by CMS upon release of the national performance measures, in accordance with 42 CFR 438.330(a), which allows CMS to specify measures and topics for performance improvement projects.

- Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector. The CMS website contains an example of available protocols.

- Develop and maintain a physician incentive program, as described in Section 6.2.1.

- Develop a member incentive program to encourage members to be personally accountable for their own health care and health outcomes, as described in Section 6.2.2. Targeted areas of performance could include the appropriate use of emergency room services, keeping appointments and scheduling appointments for routine and preventive services such as prenatal care, disease screenings, compliance with behavioral health drug therapy, compliance with diabetes treatment and well-child visits.

- Participate in any state-sponsored prenatal care coordination programs.

- Contract for an NCQA-accredited HEDIS audit and report audited HEDIS rates. A separate HEDIS audit is required for the Contractor's HIP lines of business. The HEDIS audit and report must be based upon the NCQA methodology for sampling of HEDIS data.

- Conduct a Consumer Assessment of Health Plans (CAHPS) survey and report survey results to FSSA annually. A separate CAHPS survey is required for the Contractor's HIP lines of business. The CAHPS survey must be based upon the NCQA methodology for sampling of CAHPS data.

- Include a provider relations project annually.

- Participate in other quality improvement activities, including External Quality Reviews, to be determined by FSSA.

6.1.1 Quality Assessment and Performance Improvement Committee

The Contractor shall establish an internal Quality Assessment and Performance Improvement Committee to develop, approve, monitor and evaluate the Quality Assessment and Performance Improvement Program and Work Plan. The same committee may be responsible for all of the Contractor's Medicaid lines of business. The Contractor's Medical Director and Pharmacy Director shall be active participants in the Contractor's internal Quality Management and Improvement Committee. The committee shall be representative of management staff, including provider relations, Contractor departments and community partners, advocates, members and subcontractors, as appropriate. Subcontractors providing direct services to members shall be represented on the committee.

The Contractor shall have appropriate personnel attend and participate in FSSA's regularly scheduled Quality Strategy Committee meetings. The Contractor is encouraged to recommend attendees and other stakeholders to Quality Strategy Committee meetings. Additionally, the Medical Director shall attend and participate in OMPP's Quality Strategy Committee meetings at least quarterly to update FSSA and report on the Contractor's quality management and improvement activities and

outcomes.

The Contractor shall have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, the Contractor's internal Quality Management and Improvement Committee and Quality Management and Improvement Program Work Plan. All functional units in the Contractor's organizational structure shall integrate their performance measures, operational activities and outcome assessments with the Contractor's internal quality management and improvement committee to support the Contractor's quality management and improvement goals and objectives. It is the responsibility of the Contractor to ensure that periodic reporting of quality activities is presented to the governing body, providers, and appropriate staff within the Quality Improvement Structure (IC 27-13-6-7). It is the responsibility of the Contractor to record and maintain documentation of such proceedings in a confidential manner (IC 27-13-6-8).

6.1.2 Quality Management and Improvement Program Work Plan Requirements

The Contractor's Quality Management and Improvement Committee, in collaboration with the Contractor's Medical Director and Pharmacy Director, shall develop an annual Quality Management and Improvement Program Work Plan. The plan shall identify the Contractor's quality management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals. One plan shall be developed for the Contractor's HIP line of business. The plan shall meet the HEDIS standards for reporting and measuring outcomes. The plan shall incorporate any quality improvement projects identified for the HIP program.

The Contractor shall submit its Quality Management and Improvement Program Work Plan to FSSA during the readiness review and annually thereafter. The Contractor shall provide progress reports to FSSA on no less than a quarterly basis. The Contractor must be prepared to periodically report on its quality management activities to OMPP's Quality Strategy Committee.

The Contractor shall prepare the annual Quality Management and Improvement Program Work Plan using standardized reporting templates provided by FSSA. The HIP MCE Reporting Manuals, contain instructions for the annual Quality Management and Improvement Program Work Plan and Quality Improvement Plans.

6.1.3 External Quality Review

Pursuant to federal regulation, the State shall arrange for an annual, external independent review of each Contractor's quality of, timeliness of and access to health care services in accordance with 42 CFR 438.350. The Contractor shall provide all information required for this review in the timeframe and format requested by the external quality review organization. The Contractor shall cooperate with and participate in all external quality review activities. The Contractor's Quality Management and Improvement Program should incorporate and address findings from these external quality reviews.

6.2 Incentive Programs

FSSA shall require Contractors to participate in a pay for outcomes program that focuses on rewarding Contractors' efforts to improve quality and outcomes for HIP members. FSSA shall provide, at minimum, financial performance incentives to Contractors based on performance targets in priority areas established by the State. The Contractor incentives and performance targets will be set forth in Exhibit 2.B.

FSSA shall have the right to revise measures on an annual basis and will notify the Contractor of changes to incentive measures.

Quality measures may target the following:

- Preventive care;
- Pregnancy;
- Chronic disease care including HIV and Hepatitis C;
- Pharmacy services;
- Tobacco dependence treatment;
- Behavioral health follow-up services;
- Emergency and inpatient utilization; and
- Medically frail identification (HIP Only).

Additional conditions to payment of incentive amounts are provided in Exhibit 2.B.

6.2.1 Provider Incentive Programs

Contractors shall establish a performance-based incentive system for its providers for the Contractor's HIP providers. Different provider incentives may be established for the different Medicaid lines of business. The Contractor will determine its own methodology for incentivizing providers. The Contractor shall obtain FSSA -approval prior to implementing its provider incentive program and before making any changes thereto. The State encourages creativity in designing pay for performance programs.

If the Contractor offers financial incentives to providers, these payments shall be above and beyond the minimum fee schedule established by the State.

Section 1876(i)(8) of the Social Security Act and federal regulations 42 CFR 438.10(f)(3), 42 CFR 422.208 and 42 CFR 422.210 provide information regarding physician incentive plans. The Contractor shall comply with all federal regulations regarding the physician incentive plan and supply to FSSA information on its plan as required in the regulations and with sufficient detail to permit FSSA to determine whether the incentive plan complies with the federal requirements. The Contractor shall provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.

Physician incentive plans shall comply with the following requirements:

- The Contractor will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member per section 1903(m)(2)(A)(x) of the Social Security Act, 42 CFR 422.208(c)(1), and 42 CFR 438.3(i);

- If the Contractor is putting the physician or physician group at substantial financial risk for services the physician or physician group are not providing, the Contractor meets requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.10(f)(3), 42 CFR 422.208(c)(1) and section 1903(m)(2)(A)(x) of the Social Security Act; and

- The Contractor will expand the provider incentive plans and align them with the following healthy incentive program focus areas: tobacco cessation,

substance use disorder treatment, chronic disease management, and employment related incentives.

6.2.2 Member Incentive Programs

Contractors shall establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or non- financial. The Contractor will determine its own methodology for providing incentives to members, subject to FSSA review and approval. For example, the Contractor may offer member incentives for:

- Attending all prenatal visits;
- Obtaining recommended preventive care;
- Completing the expected number of EPSDT visits;
- Complying with treatment in a disease management, care management or complex case management program;
- Making healthy lifestyle decisions such as quitting smoking or losing weight;
- Completing a health screening;
- Participation in tobacco cessation;
- Participation in substance use disorder treatment;
- Participation in chronic disease management; or
- Participation in employment related incentives.

1. Except as provided herein, the Contractor may not offer gifts or incentives greater than $200.00 for each incentive and not to exceed $300.00 total per year per individual, unless an exception is approved by FSSA. The Contractor may petition FSSA, in the manner prescribed by FSSA, for authorization to offer items or incentives greater than $200.00 for each incentive and $300.00 per year per individual if the items are intended to promote the delivery of certain preventive care services, as defined in 42 CFR 1003.110. Such incentives may not be disproportionate to the value of the preventive care service provided, as determined by FSSA. Petitions to provide enhanced incentives for preventive care shall be reviewed on a case-by-case basis, and FSSA shall retain full discretion in determining whether the enhanced incentives will be approved. In any member incentive program, the incentives shall be tied to appropriate utilization of health services and/or health-promoting behavior. For example, the member incentive programs can encourage responsible emergency room use or preventive care utilization. Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and encourage the receipt of health care services in the appropriate treatment setting. Additionally, the Contractor shall comply with those requirements found in 42 CFR 1003.110:

   "Remuneration…(4) Incentives given to individuals to promote the delivery of preventive care services where the delivery of such services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or an applicable State health care program. Such incentives may include the provision of preventive care, but may not include—

      (i) Cash or instruments convertible to cash; or
      (ii) An incentive the value of which is disproportionally large in relationship to the value of the preventive care service (*i.e.,*

either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care)…"

2. Examples of appropriate rewards include:

   - Gift certificates for groceries;
   - Phone cards; or
   - Gifts such as diaper bags or new baby "welcome" kits.

The Contractor shall obtain FSSA-approval prior to implementing its member incentive program and before making any changes thereto.

6.2.3 Notification of Pregnancy (NOP) Incentives

FSSA has implemented a Notification of Pregnancy (NOP) process that encourages MCEs and providers to complete a comprehensive risk assessment (i.e., a NOP form) for pregnant members. The Contractor shall comply with the policies and procedures set forth in the IHCP Provider Bulletin regarding the NOP process dated February 21, 2023 (BT202312), and any updates thereto.

The provider shall be responsible for completing the standard NOP form, including member demographics, any high-risk pregnancy indicators, and basic pregnancy information. The Contractor receiving the NOP shall contact the member to complete a comprehensive pregnancy health risk assessment within twenty-one (21) calendar days of receipt of completed NOP form from the provider. Only one assessment should be completed per member per pregnancy. NOP requirements and conditions for payment are set forth in the HIP MCE Policies and Procedures Manual.

To be eligible for the provider incentive payment, the NOP form shall be submitted by providers via the Portal within five (5) calendar days of the visit during which the NOP form was completed. The State shall reimburse the Contractor for NOP forms submitted according to the standards set forth in the HIP MCE Policies and Procedures Manual. This reimbursement amount shall be passed on to the provider who completed the NOP form. An additional amount will be transferred to a bonus pool. The Contractor shall be eligible to receive bonus pool funds based on achievement of certain maternity-related targets. See Exhibit 2.B for further detail regarding the NOP incentives and maternity-related targets.

The Contractor shall have systems and procedures in place to accept NOP data from the State's fiscal agent, assign pregnant members to a risk level and, when indicated based on the member's assessment and risk level, enroll the member in a prenatal case management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent.

6.3 Utilization Management Program

The Contractor shall operate and maintain its own utilization management program. The Contractor may place appropriate limits on coverage on the basis of medical necessity or utilization control criteria, provided the Contractor ensures that the amount, duration and scope of services furnished can reasonably be expected to achieve their purpose and the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services per 42 CFR 438.210(a)(3)(i), 42 CFR 438.210(a)(4)(ii)(A)-(B). The Contractor is prohibited from

arbitrarily denying or reducing the amount, duration or scope of required services solely because of diagnosis, type of illness or condition as required by 42 CFR 438.210(a)(3)(ii). The Contractor will not refer members to publicly supported health care resources as a means of avoiding costs.

The following utilization management medical criteria hierarchy have been effective for all managed care programs beginning April 1, 2023.

For select items, Contractors must use IHCP Policy as outlined below. For all other items where OMPP has criteria or guidelines in place, the Contractor cannot have criteria or guidelines that are more restrictive. The Contractor must use the full suite of non-company customized InterQual or Milliman Care Guidelines (MCG) clinical guidelines, inclusive of Medicare National Coverage Determinations and Medicare Local Coverage Determinations. For areas not addressed by IHCP Policy and MCG/InterQual, the Contractor may develop their own prior authorization--medical necessity guidelines and criteria, but they must be approved by the State and made available to the State. The hierarchy for clinical criteria and guidelines is outlined below.

Medical review criteria must follow the following hierarchy:

(1) Federal law – All review criteria must comply with federal law (if the Code of Federal Regulations has any Medicaid-specific requirements—Indiana Medicaid must comply)

(2) Indiana Code—All review criteria must comply with Medicaid-specific provisions of the Indiana Code

(3) State Plan—Review criteria are subject to the terms of the State plan (which is the State's agreement with CMS outlining the coverage and reimbursement of Indiana Medicaid services)

(4) Indiana Administrative Code—All review criteria must comply with Medicaid-specific provisions of the Indiana Administrative Code (which is given authority from the Indiana Code)

(5) IHCP Policy—This includes Provider Reference Modules, Bulletins, Banners. Contractors must follow IHCP Policy (FFS criteria) exactly for these below items:

- ABA Therapy:
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT201867.pdf
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT201953.pdf
  https://www.in.gov/medicaid/providers/files/behavioral-health-services.pdf

- Drug Testing:
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT201846.pdf
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202183.pdf
  https://www.in.gov/medicaid/providers/files/laboratory-services.pdf

- EndoPredict-Breast Cancer:
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202010.pdf

- ReliZorb:
  http://provider.indianamedicaid.com/ihcp/Banners/BR202050.pdf

- Speech Generating Devices:

http://provider.indianamedicaid.com/ihcp/Bulletins/BT202012.pdf

- Spinal Stenosis:
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT2020111.pdf

- Transplants:
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202019.pdf
  https://www.in.gov/medicaid/providers/files/surgical-services.pdf

- Bariatric Procedures:
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202240.pdf
  https://www.in.gov/medicaid/providers/files/surgical-services.pdf

- Oxygen Usage:
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202242.pdf
  https://www.in.gov/medicaid/providers/files/durable-and-home-medical-equipment-and-supplies.pdf

(6) Non-Customized National Clinical Guidelines – The Contractor may choose to use either InterQual or MCG but must use the full suite of review criteria in these platforms—including the Medicare National Coverage Determinations (NCDs) and the Medicare Local Coverage Determinations (LCDs).

- If an item is covered by MCG or InterQual—the Contractor must use the applicable MCG or InterQual guideline in lieu of a Contractor-derived guideline.

- The MCG and InterQual guideline hierarchy is as follows:

  - Must use diagnosis or procedure-specific guidelines before more general guidelines

  - Medicare (MCR) guidelines are to be used in this order: NCDs, then LCDs for Indiana

(7) Contractor-derived Guidelines (must be pre-approved by the State)

(8) Professional Society Guidelines—Guided by published peer-reviewed literature (can supersede National and Contractor-derived guidelines if specifically called out to be used in the Scope of Work— i.e., ASAM)

(9) Professional References/SME—Guided by published peer-reviewed literature

(10) Best Standards of Care—Guided by published peer-reviewed literature

OMPP reserves the right to add additional or remove the Fee-for-Service Criteria and will provide the Contractor with appropriate notice.

The Contractor is expected to always use MCG or InterQual for the following utilization management reviews; acute inpatient, skilled nursing facility, acute inpatient rehab, long-term acute care facility and behavioral health inpatient. Skilled nursing care is a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse) (see also: 42 CFR § 409.44(b).

EXHIBIT 1B

SCOPE OF WORK – HEALTHY INDIANA PLAN

For areas not addressed by the IHCP defined hierarchy, the Contractor may develop their own practice guidelines and criteria, subject to annual approval, that must be approved by the State and made available to the State. In accordance with 42 CFR 438.236(b)(1)-(2), the Contractor must establish and maintain medical management criteria and practice guidelines in accordance with State and federal regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals in the particular field and consider the needs of the Contractor's members. Pursuant to 42 CFR 438.210(b)(3) and 42 CFR 438.236(b)(3), the Contractor must consult with contracting health care professionals in developing and adopting practice guidelines and must have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with the provider that requested the services when appropriate per 42 CFR 438.210(b)(1) and 42 CFR 438.210(b)(2)(i)-(ii). The Contractor shall ensure that decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply are consistent with such practice guidelines per 42 CFR 438.236(d). Practice guidelines and criteria must be submitted to the State for approval prior to implementation by the Contractor through the standard document review process. The Contractor must periodically review and update the guidelines and post the guidelines on their website for member and provider viewing.

Pursuant to 42 CFR 438.210(b), the Contractor's utilization management system should be automated where possible to reduce burden on members and providers, e.g., automatic approvals for certain procedures with diagnoses that are consistent with the treatment.

The Contractor's prior authorization requirements must comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d). If the Contractor chooses to utilize separate guidelines for physical health and behavioral health services, the Contractor shall demonstrate that the use of separate guidelines would have no negative impact on members, and would not otherwise violate the Contractor's requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA).

The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines to providers' requests for health care or service authorizations for the Contractor's members. The Contractor shall periodically review and update the guidelines, distribute the guidelines to providers and make the guidelines available to members and potential enrollees upon request per 42 CFR 438.236(b)(4) and 42 CFR 438.236(c). Utilization management staff shall receive ongoing training regarding interpretation and application of the utilization management guidelines. The Contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by FSSA.

The Contractor shall require its providers to utilize the standardized Indiana Health Coverage Programs Prior Authorization Request Form for the submission of all prior authorization requests. In addition, the State reserves the right to standardize certain parts of the prior authorization reporting process across the MCEs, such as requiring the MCEs to adopt and apply the same definitions regarding approved, pended, denied, suspended requests, etc. When adopted, these standards shall be set forth in the MCE Reporting Manual. The State reserves the right to in the future prohibit the Contractor from requiring prior authorization when it is not required in fee-for-service.

The Contractor's utilization management program policies and procedures shall meet all NCQA standards and shall include appropriate timeframes for:

- Completing initial requests for prior authorization of services;
- Completing initial determinations of medical necessity;
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per state law;
- Notifying providers and members in writing of the Contractor's decisions on initial prior authorization requests and determinations of medical necessity; and
- Notifying providers and members of the Contractor's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity.

The Contractor shall report its medical necessity determination decisions, and shall describe its prior authorization and emergency room utilization management processes to FSSA. When the Contractor conducts a prudent layperson review to determine whether an emergency medical condition exists, the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field.

The Contractor's utilization management program shall not be limited to traditional utilization management activities, such as prior authorization. The Contractor shall maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The utilization management program shall have policies and procedures and systems in place to assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services, identify aberrant provider practice patterns (especially related to emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams), ensure active participation of a utilization review committee, evaluate efficiency and appropriateness of service delivery, incorporate subcontractor's performance data, facilitate program management and long-term quality and identify critical quality of care issues.

The Contractor's utilization management program shall link members to disease management, case management and care management, as set forth in Sections 3.7 and 3.8. The Contractor's utilization management program shall also encourage health literacy and informed, responsible medical decision making. For example, Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting.

Contractors shall also be responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

The Contractor shall monitor utilization through retrospective reviews and will identify areas of high and low utilization and identify key reasons for the utilization patterns. The Contractor shall identify those members that are high utilizers of emergency room services and/or other services and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, case management or care management services. The Contractor shall also use this data to identify additional disease management programs that are needed. Any member with emergency room utilization at least three (3) standard deviations outside of the mean for the population group shall be referred to an appropriate level of care coordination. The Contractor may use the Right Choices Program

(RCP), as described in Section 3.8, in identifying members to refer to case management or care management.

The Contractor shall monitor the pharmacy utilization of all its members where the Contractor is not responsible for paying or reimbursing the pharmacy services.

As part of its utilization review, the Contractor shall monitor access to preventive care, specifically to identify members who are not accessing appropriate preventive care services in accordance with accepted preventive care standards, such as those published by the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, or FSSA's recommended preventive care guidelines (for HIP). The Contractor shall develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards.

In order to monitor potential under- or over-utilization of behavioral health services, FSSA requires Contractors to provide separate utilization reports for behavioral health services. The Contractor shall particularly monitor use of services for its members with special needs and members with a diagnosis of severe mental illness or substance abuse. The behavioral health services report shall also separately identify the utilization of HIP members designated as medically frail.

6.3.1 Authorization of Services and Notices of Actions

Licensed physicians or licensed doctorate-level behavioral health clinicians who have appropriate clinical expertise in the treatment of a member's condition or disease must make all medical necessity decisions to deny a service authorization request (a request for the provision of a service by or on behalf of a member) or to authorize a service in an amount, duration or scope that is less than requested. Only physicians licensed in Indiana or a licensed doctorate-level behavioral health clinician may deny a service authorization request based on medical necessity criteria. The Contractor shall not provide compensation or other incentives to utilization management staff, providers or subcontractors for denying, limiting or discontinuing medically necessary services per CFR 438.210(e). FSSA may audit Contractor denials, appeals and authorization requests. FSSA may waive certain administrative requirements, including prior authorization procedures, to the extent that such waivers are allowed by law and are consistent with policy objectives. The Contractor may be required to comply with such waivers and will be provided with prior notice by FSSA. If the Contractor delegates some or all of its prior authorization function to subcontractors, the Contractor shall conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures and state and federal law.

The Contractor shall maintain a process for providers to request a peer-to-peer review. Peer-to-peer reviews shall be available for a minimum of seven (7) business days after a service authorization notification letter is received. The Contractor shall not reject a peer-to-peer review request because a service authorization denial was an administrative denial rather than a medical necessity denial.

As part of the utilization management function, the Contractor shall facilitate PMPs' requests for authorization for primary and preventive care services and shall assist the PMP in providing appropriate referral for specialty services by locating resources for appropriate referral. In accordance with federal regulations, the process for authorization of services shall comply with the following requirements:

- Second Opinions: In accordance with 42 CFR 438.206(b)(3), the Contractor

must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a provider who is qualified to give a second opinion, the Contractor shall arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

- Special Needs: In accordance with 42 CFR 438.208(c)(4), the Contractor must allow members with special health care needs, who are determined to need a course of treatment or regular care monitoring, to directly access a specialist for treatment via an established mechanism such as a standing referral from the member's PMP or an approved number of visits. Treatment provided by the specialist must be appropriate for the member's condition and identified needs.

- Women's Health: In accordance with 42 CFR 438.206(b)(2), the Contractor must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist. The Contractor must have an established mechanism to permit a female member direct access such as a standing referral from the member's PMP or an approved number of visits. The Contractor may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

The Contractor shall track all prior authorization requests in their information system. All notes in the Contractor's prior authorization tracking system shall be signed by clinical staff and include the appropriate suffix (e.g., RN, MD, etc.). For prior authorization approvals, the Contractor shall provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name of requester, (ii) title of requester, (iii) date and time of request, and (iv) prior authorization number.

For all denials of prior authorization requests, the Contractor shall maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name of requester; (ii) title of requester; (iii) date and time of request; (iv) clinical synopsis, which shall include timeframe of illness or condition, diagnosis and treatment plan; (v) clinical guideline(s) or other rational supporting the denial (e.g., insufficient documentation); (vi) denial notification letter for both members and providers; (vii) date and time of denial notification as well as the name of the individual notified of denial; and (viii) evidence that the treating practitioner was notified of appeal rights including a peer to peer review when appropriate.

The Contractor shall provide a written notice to the member and provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.404, "Notice of Action." The notice to members shall not exceed a fifth-grade reading level.

The notice shall be given within the timeframes described in the following paragraphs and 42 CFR 438.404(c).

The notification letters used by the Contractor shall be approved by FSSA prior to use and clearly explain the following:

- The qualifications of the reviewer including specialty and credentials;
- The guidelines used and reason for denial or approval;
- The action the Contractor or its subcontractor has taken or intends to take;
- The reasons for the action, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination;
- The member's or the provider's right to request an appeal with the Contractor and the process for doing so, including information on exhausting the Contractor's one level of appeal;
- The procedure to request a State fair hearing following exhaustion of the Contractor's appeal process;
- Circumstances under which expedited resolution is available and how to request it;
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services; and
- The provider's right for a peer-to-peer utilization review conversation with the reviewer and contact information. A provider must be able to schedule a specific date and time for the peer-to-peer conversation to occur.

Effective July 1, 2023, MCEs are expected to meet Prior Authorization timeliness standards per IC 27-1-37.5-11. The change includes standard Prior Authorization adjudication in five business days and urgent Prior Authorization adjudication within 48 hours. Unless otherwise provided by IC 27-1-37.5-8, IC 27-1-37.5-11, and in compliance with 42 CFR 438.210(d)(1) and 42 CFR 438.404(c)(3), the Contractor shall notify members of standard authorization decisions as expeditiously as required by the member's health condition, not to exceed five (5) business days after the request for services. An extension of up to fourteen (14) calendar days is permitted if the member or provider requests an extension or if the Contractor justifies to FSSA a need for more information and explains how the extension is in the member's best interest per 42 CFR 438.404(c)(4) and 42 CFR 438.210(d)(1). The Contractor will be required to provide its justification to FSSA upon request. Extensions require written notice to the member and shall include the reason for the extension and the member's right to file a grievance per 42 CFR 438.210(d)(1)(ii) and 42 CFR 438.404(c)(4)(i). The Contractor must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

The Contractor shall give notice on the date that the timeframes expire when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations per 42 CFR 438.404(c)(5).

If the Contractor fails to respond to a member's prior authorization request within five (5) business days of receiving all necessary documentation, the authorization is deemed to be granted.

EXHIBIT 1B

SCOPE OF WORK – HEALTHY INDIANA PLAN

In accordance with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6), for situations in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than forty-eight (48) hours after receipt of the request for service.

The Contractor may extend the forty-eight (48) hours by up to fourteen (14) calendar days if the member requests an extension or the Contractor justifies a need for additional information and how the extension is in the best interest of the member per 42 CFR 438.210(d)(2)(ii). The Contractor will be required to provide its justification to FSSA upon request.

Concurrent requests are considered urgent. To align turnaround times for all urgent requests, the State requires that concurrent requests also have a determination (decision) and notification of action within forty-eight (48) hours from time of receipt.

In compliance with 42 CFR 438.404(c)(1) and 42 CFR 431.211, the Contractor shall notify members in writing of decisions to terminate, suspend or reduce previously authorized covered services, including transfers between HIP benefit plans that result in a change to covered services, at least ten (10) calendar days before the date of action, with the following exceptions:

- Notice is shortened to five (5) calendar days if probable member fraud has been verified by the Indiana Office of the Inspector General or Attorney General per 42 CFR 438.404(c)(1) and 42 CFR 431.214.
- In accordance with 42 CFR 438.404(c)(2), notice shall be provided on the date of determination when the action is a denial of payment.
- In accordance with 42 CFR 438.404(c)(1), 42 CFR 431.213, 42 CFR 431.231(d), and section 1919(e)(7) of the Social Security Act, notice may occur no later than the date of the action in the event of:
    - The death of a member;
    - The Contractor's receipt of a signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (the member must understand the result of supplying this information);
    - The member's admission to an institution and consequential ineligibility for further services;
    - The member's address is unknown and mail directed to him/her has no forwarding address;
    - The member's acceptance for Medicaid services by another local jurisdiction;
    - The member's physician prescribes the change in the level of medical care;
    - An adverse determination made with regard to the

preadmission screening requirements for nursing facility admissions; or

- The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs or a member has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse actions for nursing facility transfers).

6.3.2 Objection on Moral or Religious Grounds

If the Contractor elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it shall furnish information about the services it does not cover as follows, in accordance with 42 CFR 438.102(b)(1)(i)(A)(1)-(2) and section 1932(b)(3)(B)(i) of the Social Security Act:

- To FSSA if it adopts the policy during the term of the Contract;
- To potential members before and during enrollment; and
- To members within ninety (90) calendar days after adopting the policy with respect to any particular service, but at least thirty (30) calendar days prior to the effective date in compliance with 438.102(b)(1)(i)(B) and 42 CFR 438.10(g)(4).

The Contractor shall provide members and potential enrollees with information on how and where to obtain counseling and referral services and if the Contractor chooses not to furnish the information, the State will provide the information to potential enrollees in accordance with 42 CFR 438.10(e)(2)(v)(C).

6.3.3 Utilization Management Committee

The Contractor shall have a utilization management committee directed by the Contractor's Medical Director. The same committee may be responsible for all State Medicaid lines of business. The committee shall be responsible for:

- Providing oversight of the Contractor UM program and structure;
- Involvement of physician and behavioral health providers in the review, evaluation, and supervision of UM activities;
- Monitoring providers' requests for rendering health care services to its members;
- Monitoring the medical appropriateness and necessity of health care services provided to its members;
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed;
- Writing policies and procedures for utilization management that conform to industry standards including methods, timelines and

individuals responsible for completing each task; and

- Confirming the Contractor has an effective mechanism in place for a plan provider or Contractor representative to respond within one hour to all emergency room providers twenty-four (24)-hours-a-day, seven (7)-days-a-week:
    - After the Contractor's member's initial emergency room screening; and,
    - After the Contractor's member has been stabilized and the emergency room provider believes continued treatment is necessary to maintain stabilization.

7.0 Program Integrity

The Indiana Office of the Attorney General, Medicaid Fraud Control Unit is the state agency responsible for the investigation of provider fraud in the Indiana Medicaid program. The OMPP Program Integrity Unit (OMPP PI), is responsible for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of Medicaid-eligible beneficiaries, and referring cases of suspected fraud to the MFCU for investigation. The OMPP PI Section identifies and recovers Medicaid waste and abuse. The FSSA Bureau of Investigations evaluates and investigates reports of suspected fraud by recipients of assistance programs and both government and contract employees.

In accordance with 42 CFR 438.3(h), the State, CMS, the OIG, the Comptroller General, and their designees have the right to:

- Inspect and audit records or documents of the Contractor and their subcontractors at any time.
- Inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time.
- Audit records or documents of the Contractor or subcontractors for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Audit and inspect any books or records of the Contractor or subcontractor pertaining to the ability of the Contractor to bear the risk of financial losses and pertaining to services performed or payable amounts under the contract per section 1903(m)(2)(A)(iv) of the Social Security Act.

Contractors shall ensure that subcontracts specify the above and other specified information regarding the State and other Federal agency rights as required in 42 CFR 438.230(c)(3)(i) and 42 CFR 438.3(k).

In accordance with 42 CFR 438.608(c)(2), 42 CFR 455.100-104, section 1124(a)(2)(A) and section 1903(m)(2)(A)(viii) of the Social Security Act, the Contractor and subcontractors shall disclose to the State any persons or corporations with an ownership or control interest in the Contractor that:

- Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity;
- Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation

secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets;

- Is an officer or director of the Contractor organized as a corporation; or
- Is a partner in the Contractor organized as a partnership.

Disclosure of the ownership or control interest information described above shall be made to the State at the following times:

- Upon proposal submission in accordance with the State's procurement process;
- When the Contractor executes a Contract with the State;
- When the State renews or extends the Contract; and/or
- Within thirty-five (35) days after any change in ownership of the Contractor.

The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting, including business transaction disclosure reporting (42 CFR 455.105) and the full ownership and control information (42 CFR 455.104) and shall further provide any additional information necessary for the FSSA to perform exclusion status checks pursuant to 42 CFR 455.436. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and the terms of this Contract, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at any time upon request.

The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any services provided by excluded individuals shall be refunded to and/or obtained by the State and/or the Contractor as prescribed in Section 7.4 Program Integrity Overpayment Recovery. Where the excluded individual is the provider of services or an owner of the provider, all amounts paid to the provider shall be refunded.

The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities. Staffing levels, at a minimum, will be equal to one full-time staff member for every 100,000 members in addition to the Special Investigation Unit Manager and the Compliance Director.

The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to sections 1128, 1156, and 1902(a)(68) of the Social Security Act. The Contractor shall also provide all documentation and information requested by OMPP PI Section or required under this section and its subsections in the form and manner mandated by the OMPP PI Section.

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

- Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to

sections 1128, 1128A, 1156, or 1842(j)(2) and 1903(i) and 1903(i)(2)(A) of the Social Security Act.

- Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person) per section 1903(i) and 1903(i)(2)(B) of the Social Security Act.

- Furnished by an individual or entity to whom the State has failed to suspend payments during any period in which the State has notified the Contractor of a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments per section 1903(i) and 1903(i)(2)(C)) of the Social Security Act.

- With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 per section 1903(i)(16) of the Social Security Act.

- With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan per section 1903(i)(17) of the Social Security Act.

Federal Financial Participation (FFP) is not available for any amounts paid to a Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

- The Contractor is controlled by a sanctioned individual under section 1128(b)(8) of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(1), 42 CFR 431.55(h), section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3); SMDL 6/12/08, SMDL 1/16/09],

- The Contractor has a contractual relationship for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as specified in section 1128(b)(8)(B) of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 431.55(h), section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08; SMDL 1/16/09],

- The Contractor has a contractual relationship for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual or entity that is, or is affiliated with a person or entity that is, debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 per 42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 438.610(b), 42 CFR 431.55(h), section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09, Executive Order No. 12549],

- The Contractor has a contractual relationship for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services,

either directly or indirectly, with any individual or entity excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 438.610(b), 42 CFR 431.55(h), section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09],

- The Contractor employs or contracts directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 per 42 CFR 438.808(a), 42 CFR 438.808(b)(3)(i), 42 CFR 438.610(a), 1903(i)(2), 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, and SMDL 1/16/09,

- The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity, or with an individual or entity that would provide those services through an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act per 42 CFR 438.808(a), 42 CFR 438.808(b)(3)(i)-(ii), 42 CFR 438.610(b), section 1903(i)(2) of the Act, 42 CFR 1002.3(b)(3), 42 CFR 1001.1901(c), SMDL 6/12/08, and SMDL 1/16/09, and

- The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 per 42 CFR 438.808(a), 42 CFR 438.808(b)(3)(ii), 42 CFR 438.610(a), section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08 and SMDL 1/16/09.

If the State learns that the Contractor has a relationship with any of the above prohibited individuals or entities, FSSA will notify the Secretary of noncompliance and determine if this Contract will be continued or terminated in accordance with 42 CFR 438.610(d)(2)-(3), 42 CFR 438.610(a)-(b). The State may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

7.1 Program Integrity Plan

Pursuant to 42 CFR 438.608(a), which sets program integrity requirements, the Contractor must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The Program Integrity Plan shall serve as Contractor's compliance plan. The Program Integrity Plan shall be submitted annually and upon request by the OMPP PI Section, and updated quarterly, or more frequently if required by the OMPP Program Integrity (PI) Section, be submitted to FSSA. The PI Plan and/or updates to the PI Plan shall be submitted through the reporting process to FSSA, who shall forward to the OMPP PI Section, ten (10) business days prior to scheduled meetings discussing the Plan. In accordance with 42 CFR 438.608(a)(1)(i)-(vii) and 42 CFR 438.230, the Plan shall include in its PI Plan provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of

EXHIBIT 1B

SCOPE OF WORK – HEALTHY INDIANA PLAN

Contractor's providers, vendors, and subcontractors (including but not limited to Pharmacy Benefits Managers) and Contractor itself, including:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.

- The designation of a Special Investigation Unit Manager, a Compliance Officer and a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract. The Plan should document that the Compliance Officer and SIU Manager shall meet with the OMPP PI Section at a minimum of quarterly and as directed by the OMPP PI Section.

- The type and frequency of training and education for the Special Investigation Unit Manager, Compliance Officer, and the organization's employees who will be provided to detect fraud. Training must be annual and address the False Claims Act, Indiana laws and requirements governing Medicaid reimbursement and the utilization of services – particularly changes in rules, and other Federal and state laws governing Medicaid provider participation and payment as directed by CMS and FSSA. Training should also focus on recent changes in rules.

- A risk assessment of the Contractor's various fraud and abuse/program integrity process. A risk assessment shall also be submitted on an "as needed" basis or at a minimum of every 6 months. This assessment shall also include a listing of the MCEs top three vulnerable areas and shall outline action plans mitigating such risks.

- An organizational chart and communication plan highlighting lines of communication between the Special Investigation Unit Manager, the Compliance Officer and the organization's employees.

- Provision for internal monitoring and auditing.

- Procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this contract.

- A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:

    - A list of automated pre-payment claims edits.
    - A list of automated post-payment claims edits.
    - A list of types of desk audits on post-processing review of claims.
    - A list of reports for provider profiling and credentialing used to aid program and payment integrity reviews.
    - A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.
    - A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials.
    - A list of references in provider and member material regarding fraud and abuse referrals.
    - A list of provisions for the confidential reporting of PI Plan violations to the designated person.

- A list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports.

- Provisions ensuring that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.

- Provisions for enforcement of standards through well-publicized disciplinary guidelines.

- Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, investigating, and reducing the potential for recurrence of fraud and abuse compliance PI Plan violations.

- Requirements regarding the reporting of any confirmed or suspected provider fraud and abuse under state or federal law to the OMPP PI Section and pursuant to Section 7.2 below.

- Assurances that no individual who reports Contractor's potential violations or suspected fraud and abuse is retaliated against.

- Policies and procedures for conducting both announced and unannounced site visits and field audits to providers defined as high risk (including but not limited to providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

- Provisions for prompt response to detected offenses, and for development of corrective action initiatives.

- Program integrity-related goals, objectives and planned activities for the upcoming year.

7.2 Program Integrity Operations

The Contractor shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard Medicaid funds against improper payments and unnecessary or inappropriate use of Medicaid. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected waste, fraud and abuse activities. Contractor shall have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud and abuse issues of Contractor's providers, vendors, and subcontractors (including Pharmacy Benefits Managers) and Contractor itself). Contractor is required to conduct and maintain at a minimum the following operations and capabilities. Contractor shall conduct all operations and deploy all capabilities described below on a routine basis and as necessary for the effective reduction of Medicaid waste, fraud and abuse.

- The Special Investigation Unit within the Contractor's structure shall have the ability to make referrals to the OMPP PI Section, and accept referrals from a variety of sources including: directly from providers (either provider self-referrals or from other providers), members, law enforcement, government agencies, etc. The Contractor shall also have effective procedures for timely reviewing, investigating, and processing such referrals.

- The Contractor will suspend all payments to a provider after the Agency determines that there is a credible allegation of fraud and has provided the Contractor with written notice of a payment suspension.

- Data mining, analytics, and predictive modeling for the identification of potential overpayments and aberrant payments/providers warranting further review/investigation.

- Provider profiling and peer comparisons of all of Contractor's provider types and specialties – at a minimum annually - to identify aberrant service and billing patterns warranting further review/audit.

- Onsite Audit capability and protocols identifying how and when the Special Investigation Unit shall conduct such onsite audits of providers.

- Medical claim audit capabilities sufficient to enable the Special Investigation Unit to audit any payment issued to any provider. This includes utilizing medical record reviewers, clinicians, coding specialists, accountants, and investigators needed for review of payments to any provider/provider type.

- Member service utilization analytics to identify members that may be abusing services. Contractor shall submit to FSSA for approval the criteria utilized for its review of its members and the referral of members to the Right Choices Program.

In accordance with 42 CFR 438.608(a)(3)-(8), the Contractor or subcontractor, to the extent that the subcontractor is delegated responsibility for coverage of services and payment of claims, shall implement and maintain arrangements or procedures for:

- Prompt notification to the State when information is received about changes in a member's circumstances that may affect the enrollee's eligibility including changes in the enrollee's residence or the death of the enrollee.

- Prompt notification to the State when information is received about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement.

- Verification, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

- All employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws, including information about rights of employees to be protected as whistleblowers per section 1902(a)(68) of the Social Security Act.

- The prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the State's program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

- The Contractor's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud per 42 CFR 455.23.

7.3 Program Integrity Reporting

The Contractor shall cooperate with all appropriate state and federal agencies, including the Indiana MFCU and the OMPP PI Section, in investigating fraud and abuse. The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21). Contractor shall provide an Audit Report to FSSA and the OMPP PI Section. The Audit Report documents all provider and member-specific program integrity activities of Contractor (i.e., the specific application of Program Integrity Plan provisions to identify specific provider and member waste, fraud and abuse), as documented below.

The Contractor shall immediately report all suspected or confirmed instances of waste, fraud and abuse to the FSSA and the OMPP PI Section. The Contractor shall use the Reporting Forms provided by the FSSA for all such reporting or such other form as may be deemed satisfactory. The Contractor shall be subject to non-compliance remedies under this Contract identified in Exhibit 2.B for willful failure to report fraud and abuse by providers, Medicaid beneficiaries/members, or applicants to the OMPP PI Section as appropriate. All confirmed or suspected cases of waste, fraud and abuse shall be discussed at the Managed Care-Program Integrity coordination meeting following the OMPP PI Section's receipt of the report unless otherwise directed by the OMPP PI Section.

The Contractor shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the Contractor shall not take any of the following actions as they specifically relate to Indiana claims:

- Contact the subject of the investigation about any matters related to the investigation;
- Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

The Contractor shall promptly provide the results of its preliminary investigation to the OMPP PI Section or to another agency designated by the OMPP PI Section.

The Contractor shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

The Contractor shall suspend all payments to a provider after FSSA determines that there is a credible allegation of fraud and has provided the Contractor with a notice of a payment suspension.

On a quarterly basis, and as otherwise directed by the OMPP PI Section, the Contractor shall submit a detailed Audit Report to FSSA which outlines the Contractor's program integrity-related activities, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives. The Audit Report shall specify current

audits, reviews, claim denials, and investigation activity of the unit, a summary of the reason for the audit/investigative activity, the disposition of any such completed activity (including detailed overpayment amounts identified or recouped), and projected upcoming activity for the following quarter. The Audit Report should also specify individual provider recoupment, repayment schedules, and actions taken for each audit or investigation. The quarterly progress report must identify recoupment totals for the reporting period. The recoupment timeframes should align with 405 IAC 1-1.4-9. The Audit Report shall also identify projected upcoming activity, including the top 20 providers on Contractor's list for audit, and the type(s) of audit(s) envisioned. The OMPP PI Section shall review and approve, approve with modifications, or reject the Audit Report and specify the grounds for rejection. Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the OMPP PI Section) must also be submitted in the Audit Report.

In accordance with 42 CFR 438.608(d)(3), 42 CFR 438.604(a)(7), and 42 CFR 438.606, the Contractor shall report annually to the State on the recoveries of overpayments. In accordance with 42 CFR 438.608(d)(1)(ii)-(iii), the Contractor must have a process, timeframes, and documentation required for reporting the recovery of all overpayments and for payment of recoveries in situations where the Contractor is not permitted to retain some or all of the recovery.

The Contractor shall notify FSSA within one (1) business day upon discovery of a HIPAA or other security breach.

7.4 Program Integrity Overpayment Recovery

The Contractor has primary responsibility for the identification of all potential waste, fraud and abuse associated with services and billings generated as a result of this Contract. In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified and recovered by Contractor.

The Contractor will have policies and procedures in place to fully comply with 42 CFR 438.608. The Contractor or subcontractor with delegated responsibility for coverage of services and payment of claims, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State per 42 CFR 438.608(a)(2).

The Contractor must maintain relevant documentation for a minimum of seven (7) years. In accordance with 42 CFR 438.608(d)(1)(i), the Contractor shall have retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. Quarterly and annual reporting of recoveries will be made in accordance with the guidance in the MCE Reporting Manual.

In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by the OMPP PI Section, FSSA may recover any identified overpayment directly from the provider or may require Contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Section. The OMPP PI Section may also take disciplinary action against any provider identified by Contractor or the OMPP PI Section as engaging in inappropriate or abusive billing or service provision practices.

If a fraud referral from Contractor generates an investigation and/or corresponding legal action results in a monetary recovery to IHCP, the reporting Contractor will be entitled to share in such recovery following final resolution of the matter (settlement agreement/final court judgment) and following payment of recovered funds to the State of Indiana. The

Contractor's share of recovery will be as follows:

- From the recovery, the State (including the IMFCU) shall retain its costs of pursuing the action, including any costs associated with OMPP PI Section operations associated with the investigation, and its actual documented loss (if any). The State will pay to the Contractor the remainder of the recovery, not to exceed the Contractor's actual documented loss. Actual documented loss of the parties will be determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.

- If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the Contractor about potential settlement. The State may consider the Contractor's preferences or opinions about acceptance, rejection or the terms of a settlement, but they are not binding on the State.

- If final resolution of a matter does not occur until after the Contract has expired, the preceding terms concerning disposition of any recovery and consultation with the Contractor shall survive expiration of the Contract and remain in effect until final resolution of a matter referred to the IMFCU by the Contractor under this section.

If the State makes a recovery from a fraud investigation and/or corresponding legal action where the Contractor has sustained a documented loss but the case did not result from a referral made by the Contractor, the State shall not be obligated to repay any monies recovered to Contractor, but may do so at its discretion. Funds recovered as a result of a multi-state fraud investigation/litigation, however, will be shared with Contractor as prescribed for funds recovered as a result of Contractor’s fraud referral absent extenuating circumstances.

The Contractor is prohibited from the repayment of state-, federally-, or Contractor-recovered funds to any provider when the issues, services or claims upon which the repayment is based meets one or more of the following:

- The funds from the issues, services or claims have been obtained by the State or Federal governments, either by the State directly or as part of a resolution of a state or federal audit, investigation and/or lawsuit, including but not limited to false claims act cases; or

- When the issue, services or claims that are the basis of the repayment have been or are currently being investigated by the OMPP PI Section, the Federal Medicaid Integrity Contractor (MIC), Contractor, Indiana MFCU, or Assistant United State Attorney (AUSA), are the subject of pending Federal or State litigation, or have been/are being audited by the State Recovery Audit Contractor (RAC).

This prohibition described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The Contractor shall check with the OMPP PI Section before initiating any repayment of any program integrity related funds to ensure that the repayment is permissible.

7.5 Auditing Program Integrity Operations

The OMPP PI Section may conduct audits of Contractor’s Special Investigation (SI) Unit activities to determine the effectiveness of Contractor’s operations. Such audit activities

may include conducting interviews of relevant staff, reviewing all documentation and systems used for Special Investigation Unit activities, and reviewing the SI Unit's performance metrics. The OMPP PI Section may issue a corrective action or performance improvement plan and outline timelines for improvement measures. The failure to adhere to operational improvement measures may result in the State's imposing liquidated damages up to the amount of overpayments recovered from Contractor's providers by OMPP PI Section audits for the preceding calendar year, or imposing other non-compliance remedies including liquidated damages as outlined by Exhibit 2.B.

8.0 Information Technology (IT) Systems

The Contractor must have Information Technology (IT) systems sufficient to support the HIP program requirements, and the Contractor must be prepared to submit all required data and reports in the format specified by FSSA. This may include, at the State's discretion, an administrative data extract in a prescribed format outlined in the Reporting Manual. The Contractor must maintain IT systems with capabilities to collect, analyze, integrate and report information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility in accordance with 42 CFR 438.242(a). The IT system must perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this section. The Contractor must be capable of collecting data on enrollee and provider characteristics as specified by the State and on all services furnished to enrollees through an encounter data system as required by 42 CFR 438.242(b)(2). The Contractor's IT systems must support provider electronic submission of authorization requests, authorization appeals, claims, claim disputes and claim appeals. The Contractor's IT systems must integrate HIP pharmacy data from the State fiscal agent for HIP member benefit plan assignment, including any applicable medically frail designation or pregnancy diagnosis.

In the event the State's technical requirements require amendment during the term of the Contract, the State will work with Contractors in establishing the new technical requirements. The Contractor shall be capable of adapting to any new technical requirements established by the State, and the State may require the Contractor to agree in writing to the new requirements. After the Contractor has agreed in writing to a new technical requirement, any Contractor-initiated changes to the requirements shall require FSSA approval and FSSA may require the Contractor to pay for additional costs incurred by the State in implementing the Contractor-initiated change.

The Contractor shall develop processes for development, testing, and promotion of system changes and maintenance. The Contractor shall notify FSSA at least thirty (30) calendar days prior to the installation or implementation of minor software and hardware changes, upgrades, modifications or replacements. The Contractor shall notify FSSA at least (90) calendar days prior to the installation or implementation of major software or hardware changes, upgrades, modifications or replacements. "Major" changes, upgrades, modifications or replacements are those that impact mission critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, encounter data management, and any other processing affecting the Contractor's capability to interface with the State or the State's contractors. The Contractor shall ensure that system changes or system upgrades are accompanied by a plan which includes a timeline, milestones and adequate testing to be completed prior to implementation. The Contractor shall notify and provide such plans to FSSA upon request in the timeframe and manner specified by the State.

The Contractor shall have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164), which address security and privacy of

individually identifiable health information.

The Contractor's IS shall support HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier requirements and Privacy and Security Rule standards. The Contractor's electronic mail encryption software for HIPAA security purposes shall provide no less protection than the State's electronic mail encryption software. The Contractor's IS plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308);
- Physical safeguards (45 CFR 164.310); and
- Technical safeguards (45 CFR 164.312).

The Contractor shall make data available to FSSA and, upon request, to CMS in accordance with 42 CFR 438.242(b)(4). In accordance with 42 CFR 438, subpart H, which relates to certifications and program integrity, the Contractor shall submit all data, including encounter claims, under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the Contractor's data.

The Contractor shall comply with all Indiana Office of Technology (IOT) standards, policies and guidelines, which are available online at http://in.gov/iot/2394.htm. All hardware, software and services provided to or purchased by the State shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d) and IC 4-13.1-3. Any deviation from these architecture requirements shall be approved in writing by IOT in advance. In addition to the IOT policies, the Contractor shall comply with all OMPP Application Security Policies. Any deviation from these architecture requirements must be approved in writing by IOT in advance.

In addition to the IOT policies, the Contractor shall comply with all FSSA Application Security Policies. Any deviation from the policies must be approved in writing from FSSA. Furthermore, Contractors must be willing to accept FSSA's Confidentiality, Security and Privacy of Personal Information contractual terms.

8.1 Master Test Plan

Software testing is the process of evaluation to detect differences between given input and expected output. Testing assesses the quality of the product. Software testing is a verification and validation process that should be done during the development process.

The Contractor's Master Test Plan should be fully inclusive of the testing phases listed below. Any deviations from this list of phases (additions or deletions) will need to be explained and justified in the State approved Contractor's Master Test Plan.

1. Unit Testing (UT)
   Defined as testing conducted on individual units (components) of an integrated system, designed to validate that each unit performs as designed.

2. System Integration Testing (SIT)
   Defined as testing conducted on a complete, integrated system to evaluate the system's compliance with its specified requirement.

3. External Contractor and/or Partner Testing
   Defined as independent testing to demonstrate that the applicable phase of the

system and the system as installed conforms to the application system specifications.

4. User Acceptance Testing (UAT)
   Defined as acceptance testing often done by the customer to ensure that the delivered product meets the requirements and works as the customer expected. The Contractor is required to provide 'proof of life' (aka ‘proof of concept’) demonstrations for all systems prior to UAT.

5. End-to-End (E2E) Testing
   Defined as testing that the flow of an application is performing as designed from start to finish to identify system dependencies and ensure that the right information is passed between various system components and systems.

6. Regression Testing
   Defined as testing after modification of a system, component, or a group of related units to ensure that the modification is working correctly and is not damaging or imposing other modules to produce unexpected results.

7. Stress / Volumetric Testing
   Defined as testing to evaluate how the application or system behaves under unfavorable conditions and how it recovers when going back to normal usage. Stress Testing is conducted at upper and beyond limits of the specifications.

8. Security Testing
   Contractor may be subject to either the creation of, or full cooperation with, Security Assessment or testing as prescribed by state. This may include Penetration Testing or SOC-1 audits.

The State requires the following specific criteria to be formally adopted, included, or executed as part of the contractor’s holistic testing plan:

1. Each Test Plan shall include, but not be limited to, the following:

   a. Testing Strategy, including dates and participants
   b. Test Scenarios and Cases
   c. Full Requirement Tracing
   d. Input Data
   e. Expected Results
   f. Actual Results
   g. Status
   h. Secondary Result Validation

2. Provide for at least a month between testing completion and Go Live.

3. Access must be directly provided to the correct testing environments at no cost to any participant internal or external to the Contractor.

4. Participate in test phases including other parties (such as Contractor or User Acceptance testing) not just by providing access, but by developing test plans and scenarios for these phases as well, and providing the required input data and unique configurations to support all internal and external test cases.

5. Cooperation and collaboration with all contractors, stakeholders and testing partners is required by the State to ensure each test phase is successful. This collaboration shall extend to test phases run by other partners external to those managed by the Contractor in order to ensure the success of the effort overall.

Furthermore, the State requires that contractors adhere to its criteria for and definition of defects listed below in Table 1, their severities, and the defined actions required by Severity. The State has unilateral authority to assign or change a defect level:

Defect Severity Definitions and Required Actions

Severity	Definition / Criteria for Assignment	Required Schedule / Action to Resolve
1	Catastrophic - Functionality causes critical impact / system failure. Any defect that causes major system impacts or interface issues and is not acceptable for production. A serious deviation from requirements which prohibits the stakeholder from accurately completing a major piece of functionality.	Any Severity 1 defects must be resolved, re-tested and the fix confirmed prior to implementation.
2	Major - Major functions are/would be disabled; no workaround exists.	Any Severity 2 defects must be resolved, re-tested and the fix confirmed prior to implementation
3	Medium - Major functions are/would be disabled; workaround available and acceptable to the State. A minor deviation from requirements which prohibits the stakeholder from completing a minor piece of functionality accurately and there may or may not be an appropriate workaround acceptable to the State. Note: The State may make determinations that certain errors classified as “Minor deviations” are to be corrected before the system is ready for production.	Any Severity 3 defects must have a state-approved workaround, including detailed operating procedures for the intervention and an implementation plan for the automated fix. Final fix must be re-tested, implemented, and confirmed within 90 days of Go Live
4	Minor – minor functions are/would be disabled	Any severity 4 defects must be resolved, re-tested, implemented and confirmed within 180 days of Go Live
5	Cosmetic – a deviation from requirements, which does not prohibit processing of a piece of functionality, or indicates an internal issue that is not considered a defect in the system, but requires attention to ensure quality of the system.	Any severity 5 defects must be resolved, re-tested, implemented and confirmed within 365 days of Go Live

8.2 Business Contingency and Disaster Recovery Plans

IT system contingency planning shall be developed in accordance with the requirements of this section and with 45 CFR 164.308, which relates to administrative safeguards. Contingency plans shall include: Data Backup plans, Disaster Recovery plans and Emergency Mode of Operation plans. Application and Data Criticality analysis and Testing and Revisions procedures shall also be addressed within the Contractor’s contingency plan

documents. The Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternative location under emergency conditions within twenty-four (24) hours of identification of a disaster. The Contractor shall protect against hardware, software and human error. The Contractor shall maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back- ups and disaster recovery. The Contractor shall maintain full and complete back-up copies of data and software, and shall back up on tape or optical disk and store its data in an off-site location approved by FSSA.

For purposes of this Scope of Work, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Contractor's or its subcontracting entities' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. The Contractor shall take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status. Disasters may include natural disasters, human error, computer virus or malfunctioning hardware or electrical supply. The Contractor must take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status.

The Contractor shall notify FSSA, at minimum, within two (2) hours of discovery of a disaster or other disruptions in its normal business operations. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, encounter data management, and any other processing affecting the Contractor's capability to interface with the State or the State's contractors. Depending on the anticipated length of disruption, FSSA, in its discretion, may require the Contractor to provide FSSA a detailed plan for resuming operations. In the event of a catastrophic or natural disaster (including, but not limited to, fire, flood, earthquake, storm, hurricane, war, invasion, act of foreign enemies, or terrorist activities), the Contractor shall resume normal business functions at the earliest possible time, not to exceed thirty (30) calendar days. If deemed appropriate by the State, the Contractor shall coordinate with the State fiscal agent to restore the processing of claims by *Core*MMIS if the claims processing capacity cannot be restored within the Contractor's system. In the event of other disasters or system unavailability caused by the failure of systems and technologies within the Contractor's span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply), the Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten (10) calendar days.

The Contractor and HIP subcontractors' responsibilities include, but are not limited to:

- Supporting immediate restoration and recovery of lost or corrupted data or software.

- Establishing and maintaining, in an electronic format, a weekly back-up and a daily back- up that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations and user documentation.

- Demonstrating an ability to meet back-up requirements by submitting and maintaining Data Backup and Disaster Recovery Plans that address:

- Checkpoint and restart capabilities and procedures;
- Retention and storage of back-up files and software;
- Hardware back-up for the servers;
- Hardware back-up for data entry equipment; and
- Network back-up for telecommunications.

- Developing coordination methods for disaster recovery activities with FSSA and its contractors to ensure continuous eligibility, enrollment and delivery of services.

- Providing the State with business resumption documents, reviewed and updated at least annually, such as:

  - Disaster Recovery Plans
  - Business Continuity and Contingency Plans
  - Facility Plans
  - Other related documents as identified by the State

At no additional charge to the State, the Contractor shall be required to have in a place a comprehensive, fully tested IT business continuity/disaster recovery plan (ITBCP) that, at minimum, meets the requirements of NIST SP800-34. The ITBCP shall be submitted to the State within ninety (90) calendar days of Contract award with, at minimum, annual updates thereafter. The Contractor shall make reasonable updates and changes to its ITBCP as requested from time-to-time by the State or as otherwise may be required by applicable federal or State laws and regulations:

- The ITBCP will, at a minimum, meet the requirements of NIST SP800-34.

- The State and the Contractor will mutually agree on reasonable Recovery Point Objectives and Recovery Time Objectives reflective of the State's business requirements and the critical nature of the Contractor's systems and services in support of the associated State business operations:

  - At a minimum, the Recovery Time Objectives will be no more than 48 hours;
  - At a minimum, the Recovery Point Objectives will be no more than 24 hours; and
  - These Objectives will be reviewed and, as necessary, modified on an annual basis.

- The Contractor will coordinate its ITBCP with FSSA's own IT business continuity/disaster recovery plans, including other State solutions with which the Contractor's system interfaces to assure appropriate, complete, and timely recovery:

  - The Contractor agrees to coordinate the development, updating, and testing of its ITBCP with the State in the State's development, updating, and testing of its Continuity of Operations Plan (COOP), as required by State policy and Homeland Security Presidential Directive (HSPD) 20.

- The ITBCP will be based on the agreed upon Recovery Point Objectives and Recovery Time Objectives, and a comprehensive assessment of threat and risk to be performed by the Contractor, with such threat and risk assessment updated on no less than annually by the Contractor (to reflect technological, Contractor business, and State business operations changes, and other appropriate factors).

- The State expects the Contractor's ITBCP to be tested by Contractor no less than annually, with such testing being comprehensive in nature and scope assuring point-to- point testing in meeting the agreed upon Recovery Point Objectives and Recovery Time Objectives.
    - The first test of the Contractor's ITBCP is expected to be performed within ninety (90) calendar days of the State's award of a contract to the Contractor.
- The Contractor will provide the State with an annual report regarding the Contractor's (no less than) annual testing and updating of its ITBCP, including the results of the annual test, including failure points and corrective action plans.
    - The first such report is expected within thirty (30) calendar days of the Contractor's completion of its first test of its ITBCP.
- The Contractor will submit to the State a copy of its ITBCP, including annual updates.
    - The first copy of the ITBCP will be expected within ninety (90) calendar days of the State's award of a contract to the Contractor.
- The Contractor further agrees to make reasonable updates and changes to its ITBCP as requested from time-to-time by the State or as otherwise may be required by applicable federal or state laws and regulations.

8.3 Member Enrollment Data Exchange

The Contractor shall be responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member. The Contractor shall reconcile its eligibility and capitation records monthly. For the Contractor's HIP members, the monthly reconciliation shall also include a reconciliation of any state POWER Account contributions and/or recoupment records received during the month. In accordance with 42 CFR 438.608(c)(3), if the Contractor discovers a discrepancy in eligibility, capitation or POWER Account payment information, the Contractor shall notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records. The Contractor shall return any capitation or POWER Account overpayments to FSSA within forty-five (45) calendar days of discovering the discrepancy. If the Contractor receives either enrollment information or capitation for a member, and/or a state POWER Account contribution for a HIP member, the Contractor is financially responsible for the member. If the Contractor discovers a discrepancy in eligibility or capitation information, the Contractor must notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records. The Contractor must return any capitation overpayments to FSSA within forty-five (45) calendar days of discovering the discrepancy. If the Contractor receives either enrollment information or capitation for a member, the Contractor is financially responsible for the member.

The Contractor shall accept enrollment data in electronic format, currently via secure file transfer protocol ("FTP"), as directed by FSSA and as detailed in the Indiana Health Coverage Program Companion Guide – 834 Contractor Benefit Enrollment and Maintenance Transaction ("834 Companion Guide), which shall be updated by FSSA prior to the Contract effective date to include updated HIP protocols. FSSA reserves the right to amend the 834 Companion Guide during the Contract term. The current 834 Companion

Guide is provided in the Bidders' Library as an example only. The Contractor is responsible for loading the eligibility information into its claims system within five (5) calendar days of receipt. In addition, the Contractor's IT systems must accommodate the State's member identification number (MID) for each member and the case number.

The Contractor's information systems shall accommodate the State's 12-digit member identification number (MID) for each member.

8.4 Provider Network Data

The Contractor shall submit provider network information to the State fiscal agent via the IHCP Provider Healthcare Portal. The Contractor shall keep provider enrollment and disenrollment information up-to-date. The Contractor shall enter updates into the Portal no less frequently than on the 1st and 15th day of each month, or as otherwise directed by the State. More information regarding provider network data will be available in the HIP Policies and Procedures Manual.

8.5 Claims Processing

8.5.1 Claims Processing Capabilities

The Contractor must comply with Section 6504(a) of the ACA, which requires that claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation to meet the requirements of section 1903(r)(1)(F) of the Social Security Act in accordance with 42 CFR 438.242(b)(1). The Contractor shall demonstrate and maintain the capability to process and pay provider claims for services rendered to the Contractor's members, in compliance with HIPAA, including National Provider Identification (NPI). The Contractor shall be able to price specific procedures or encounters (depending on the agreement between the provider(s) and the Contractor) and to maintain detailed records of remittances to providers. In accordance with Section 2.6, FSSA must pre-approve the Contractor's delegation of any claims processing function to a subcontractor, such as but not limited to a Dental Benefits Manager or Transportation Broker. The Contractor must notify FSSA and secure FSSA's approval of any change to sub-contracting arrangements for claims processing. The Contractor shall use all applicable National Correct Coding Initiative (NCCI) edits in the processing of claims, except where State policy requires payment methodologies that contradict with NCCI edits. The Contractor shall use code sets and standards established and maintained by FSSA.

The Contractor shall develop policies and procedures to monitor claims adjudication accuracy and shall submit its policies and procedures for monitoring its claims adjudication accuracy to FSSA for review and approval.

The out-of-network provider filing limit for submission of claims to the Contractor is one hundred and eighty (180) days from the date of service. This conforms with the filing limit under the Medicaid state plan (42 CFR 447.45(d)(4)). The in-network provider filing limit is established in the Contractor's provider agreements pursuant to the guidelines set forth in Section 5.4, which generally require in-network providers to submit claims within ninety (90) calendar days from the date of service. Timely filing limits are automatically waived in the instances of eligibility updates/retroactivity, agency error, or any other condition established by FSSA in rule or policy. The Contractor's IT systems must allow for the bypassing of timely filing limits or indication of alleged waiver for these established conditions that does not solely rely on the appeals or grievance processes outlined in this Contract.

The Contractor shall have written policies and procedures for registering and responding to claims disputes for out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6-1.

8.5.2 Compliance with State and Federal Claims Processing Regulations

The Contractor shall have a claims processing system to support electronic claims submission for both in- and out-of-network providers. The Contractor's system shall process all claim types such as professional and institutional claims. The Contractor shall comply with the claims processing standards and confidentiality standards under IC 12-15-13-1.6 and IC 12-15-13-1.7, and any applicable federal regulations, including HIPAA regulations related to the confidentiality and submission requirements for protected health information (PHI). The Contractor shall ensure that communication with providers, particularly out-of- network providers, and submission requirements are efficient and not burdensome for any providers. The Contractor shall be prohibited from requiring out-of-network providers to establish a Contractor-specific provider number in order to receive payment for claims submitted. The Contractor shall not require providers to bill using any number other than the FSSA assigned Member ID number.

8.5.3 Claims Payment Timelines

The Contractor shall pay providers for covered medically necessary services rendered to the Contractor's members in accordance with the standards set forth in IC 12-15-13-1.6 and IC 12-15-13-1.7, unless the Contractor and provider agree to an alternate payment schedule and method. The Contractor shall also abide by the specifications of 42 CFR 447.45(d)(5) and (d)(6), 42 CFR 447.46, and sections 1902(a)(37)(A) and 1932(f) of the Social Security Act which require the Contractor to ensure that the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

The Contractor shall pay or deny electronically filed clean claims within twenty-one (21) calendar days of receipt. A "clean claim" is one in which all information required for processing the claim is present. The Contractor shall pay or deny clean paper claims within thirty (30) calendar days of receipt. If the Contractor fails to pay or deny a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, the Contractor shall also pay the provider interest at the rate set forth in IC 12-15-21-3. The Contractor shall pay interest on all clean claims paid late (i.e., in- or out-of- network claims) for which the Contractor is responsible, unless the Contractor and provider have made alternate written payment arrangements. Unclean claims must be rejected or denied within one year of receipt.

The Contractor shall meet the requirements set forth in IC 27-13-36.2-3 and notify providers of deficiencies in claims within the set timelines in State statute.

All providers must be offered on their provider agreement the option to select Electronic Fund Transfer (EFT) for provider payments. The Contractor shall develop a plan to issue payments predominantly via EFT and submit to the State for approval.

The Contractor shall not violate the claims payment provisions and timeframes that apply to accident and sickness insurers and HMOs under IC 27-8-5.7.

FSSA shall have the right to perform a random sample audit of all claims, and expects the Contractor to fully comply with the requirements of the audit and provide all requested documentation, including provider claims and encounters submissions.

8.5.4 Rate Update Timeliness

The Contractor shall have policies and procedures in place to load new fee schedules and fee schedule updates from FSSA into their claims processing systems. The Contractor shall update fee schedules within thirty (30) days of the fee schedule effective date or date of notice of the fee schedule change, whichever is later. Failure to adhere to this requirement will result in corrective action, as described in Exhibit 2.B Contract Compliance and Pay for Outcomes.

8.5.5 Medicaid National Correct Coding Initiative (NCCI)

Disclosure of information contained in the Medicaid National Correct Coding Initiative (NCCI) files shall be limited to only those responsible for the implementation of the quarterly State Medicaid NCCI edit files. Disclosure shall not be made prior to the start of the new calendar quarter.

After the start of the new calendar quarter, the Contractor may disclose only non-confidential information contained in the Medicaid NCCI edit files that is also available to the general public found on the Medicaid NCCI webpage. The Contractor agrees to use any non-public information from the quarterly State Medicaid NCCI edit files only for any business purposes directly related to the implementation of the Medicaid NCCI methodologies in Indiana.

New, revised, or deleted Medicaid NCCI edits shall not be published or otherwise shared by the Contractor with individuals, medical societies, or any other entities unless they were a Contracted Party prior to the posting of the Medicaid NCCI edits on the Medicaid NCCI webpage. Implementation of new, revised, or deleted Medicaid NCCI edits shall not occur prior to the first day of the calendar quarter. Only FSSA has the discretion to release additional information for selected individual edits or limited ranges of edits from the NCCI files shared with the Contractor. FSSA will impose penalties, up to and including loss of Contract, for violations of this confidentiality agreement relating to use of the Medicaid NCCI files.

8.6 Encounter Data Submission

The Contractor shall have policies, procedures and mechanisms in place to support the encounter data reporting process described below and in the State's Companion Guides. The Contractor shall strictly adhere to the standards set forth in the State fiscal agent's Companion Guides, as may be amended from time to time, such as the file structure and content definitions (including any content definitions as may further be interpreted or defined by FSSA).

In accordance with 42 CFR 438.242(c) and 42 CFR 438.818, the Contractor must provide for:

- Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees;

- Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs;

- Submission of all enrollee encounter data, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR 438.818; and

- Specifications for submitting encounter data to the State in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate.

The quality of Contractor's encounter data submissions shall be subject to audit and validation. Contractor shall fully comply with all such audit and validation activities including, but not limited to, attending meetings, providing background information on encounter data submissions, providing access to systems, records, and personnel that can assist auditors with their work, and timely responding to all information requests from the State or its auditors. The Contractor technical meetings with FSSA and the Fiscal Agent provide a forum for Contractor technical support staff to participate in the development of the data exchange process and ask questions related to data exchange issues, including encounter data transmission and reporting issues. The Contractor shall report any problems it is experiencing with encounter data submissions and reporting at this monthly meeting and to its designated FSSA Policy Analyst.

8.6.1 Definition and Uses of Encounter Data

Encounter data provides reports of individual patient encounters with the Contractor's health care network. These claims contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts and rendering providers' identification numbers and other detailed claims data required for quality improvement monitoring and utilization analysis. The Contractor shall submit an encounter claim to the State fiscal agent or its designee for every service rendered to a member for which the Contractor either paid or denied reimbursement per 42 CFR 438.604(a)(1), 42 CFR 438.606, and 42 CFR 438.818.

The State shall primarily use the encounter data to make tactical and strategic decisions related to the HIP program and to the Contract. In accordance with 42 CFR 438.604(a)(2), 42 CFR 438.606, 42 CFR 438.3, and 42 CFR 438.5(c), the Contractor's submitted data shall be the basis of which the State certifies the actuarial soundness of capitation rates to the Contractor, including base data that is generated by the Contractor. The State shall primarily use encounter data to calculate the Contractor's future capitation rates, with alternative data sources utilized as appropriate to meet actuarial and federal standards. Encounter data will also be used to calculate incentive payments to the Contractor, monitor quality and to assess the Contractor's Contract compliance. See Exhibit 2.B for a schedule of liquidated damages that FSSA will assess for non-compliance with encounter data submission requirements.

8.6.2 Reporting Format and Batch Submission Schedule

The Contractor shall submit institutional, pharmacy, dental, vision, transportation and other professional encounter claims in an electronic format that adheres to the data specifications in the State fiscal agent's Companion Guides and any other state or federally mandated electronic claims submission standards, or be subject to liquidated damages. A diagnosis code and DRG, as applicable, is a required data field and shall be included on all encounter claims. The Contractor's encounter claims

shall include the National Drug Codes (NDCs) when an encounter involves products or services with NDCs, including medical and institutional claims where medications with NDCs are included and billed separately. An indication of claim payment status and an identification of claim type (i.e., original, void or replacement) is also required, in the form designated by FSSA.

The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week, or other date and time as specified by the State.

Per 42 CFR 438.3(s)(2), all drug utilization data that is necessary for the State to bill manufacturers for rebates must be submitted to the State no later than 45 calendar days after the end of each quarterly rebate period.

FSSA will use an overall average of calendar month submissions to assess compliance with this encounter claim submission requirement. The State shall require the Contractor to submit a corrective action plan and shall assess liquidated damages for failure to comply with the encounter claims submission requirements. See Exhibit 2.B for a schedule of liquidated damages FSSA shall assess for non-compliance with this requirement. Only data and information accepted by the data warehouse by June 30 shall be considered for the next year's capitation rate adjustments. For example, only encounters and information accepted by June 30, 2022 will be considered for 2023 rate setting purposes.

8.6.3 Encounter Claims Quality

The Contractor shall have written policies and procedures to address its submission of encounter claims to the State. These policies shall address the submission of encounter data from any subcapitated providers or subcontractors. At least annually, or on a schedule determined at the discretion of the State, the Contractor shall submit an encounter claims work plan that addresses the Contractor's strategy for monitoring and improving encounter claims submission.

The Contractor shall comply with the following requirements:

- Timeliness of Contractor's Encounter Claims Submission: The Contractor shall submit ninety eight percent (98%) of adjudicated claims within twenty-one (21) calendar days of adjudication. The Contractor shall submit void/replacement claims within two (2) years from the date of service.

- Compliance with Pre-cycle Edits: The State or its designee will assess each encounter claim for compliance with pre-cycle edits. The Contractor must correct and resubmit any encounter claims that do not pass the pre-cycle edits.

- Accuracy of Encounter Claims Detail: The Contractor shall demonstrate that it implements policies and procedures to ensure that encounter claims submissions are accurate; that is, that all encounter claims detail being submitted accurately represents the services provided and that the claims are accurately adjudicated according to the Contractor's internal standards and all state and federal requirements. FSSA shall have the right to monitor Contractor encounter claims for accuracy against the Contractor's internal criteria and its level of adjudication accuracy. FSSA shall regularly monitor the Contractor's accuracy by reviewing the Contractor's compliance with its

internal policies and procedures for ensuring accurate encounter claims submissions and by performing a random sample audit of all claims. FSSA expects the Contractor to fully comply with the requirements of the review and audit and to provide all requested documentation, including provider and encounter claims submissions and medical records. FSSA shall require the Contractor to submit a corrective action plan and will require non- compliance remedies for the Contractor's failure to comply with encounter claims accuracy reporting standards.

- Completeness of Encounter Claims Data: The Contractor shall have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers, i.e., for every service provided, providers shall submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions, including National Drug Codes as applicable. The Contractor shall also have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided.

The Contractor shall adhere to CMS encounter submission requirements under 42 CFR 438.242. Encounters shall include allowed amounts and paid amounts. Subcontractor administrative costs must be excluded from paid amounts.

As part of its annual encounter claims work plan, the Contractor shall demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance. FSSA may require the Contractor to demonstrate, through report or audit, that this monitoring system is in place and that the Contractor is regularly monitoring the completeness of claims and encounter data and ensuring that the Contractor is meeting FSSA's completeness requirements.

FSSA shall require the Contractor to submit a corrective action plan and will require non- compliance remedies for the Contractor's failure to comply with encounter claims completeness reporting standards, as identified in the Encounter Data Quality Validation template.

8.7 Third Party Liability (TPL) Issues

If a member is also enrolled in or covered by another insurer, the Contractor is fully responsible for coordinating benefits so as to maximize the utilization of third-party coverage. The Contractor shall share information regarding its members, especially those with special health care needs, with other payers as specified by FSSA and in accordance with 42 CFR 438.208(b), which relates to coordination of care. In the process of coordinating care, the Contractor shall protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164.

The Contractor shall be responsible for payment of the member's coinsurance, deductibles, co- payments and other cost-sharing expenses, but the Contractor's total liability shall not exceed what the Contractor would have paid in the absence of TPL, after subtracting the amount paid by the primary payer. The Contractor shall coordinate benefits and payments with the other insurer for services authorized by the Contractor, but provided outside the Contractor's plan. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the member or provider of service by the Contractor shall not prevent or unduly delay a member from receiving medically necessary services. The Contractor remains responsible for the costs incurred by the member with respect to care and services which are included in the Contractor's capitation rate, but which are not

covered or payable under the other insurer's plan.

The Contractor must have a signed Coordination of Benefits Agreement (COBA) with CMS and participate in the automated crossover claim process administered by Medicare per 42 CFR 438.3(t).

In accordance with IC 12-15-8 and 405 IAC 1-1-15, FSSA has a lien upon any money payable by any third party who is or may be liable for the medical expenses of a Medicaid recipient when Medicaid provides medical assistance. The Contractor may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

8.7.1 Coordination of Benefits

If the HIP member primary insurer is a commercial HMO and the Contractor cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the Contractor's rules, the Contractor may submit to the Enrollment Broker a written request for disenrollment. The request shall provide the specific description of the conflicts and explain why benefits cannot be coordinated. The Enrollment Broker will consult with FSSA and the request for disenrollment will be considered and acted upon accordingly.

The types of other health insurance coverage the Contractor should coordinate with include insurance such as worker's compensation insurance and automobile insurance. Per 45 CFR § 144.103, health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

8.7.2 Collection and Reporting

The Contractor will be responsible for identifying, collecting and reporting third party liability coverage and collection information to the State. As third-party liability information is a component of capitation rate development, the Contractor must maintain records regarding third party liability collections and report these collections to FSSA in the timeframe and format determined by FSSA. The Contractor will retain all TPL collections made on behalf of its members.

8.7.3 Cost Avoidance

The Contractor's TPL responsibilities include cost avoidance. When the Contractor is aware of other insurance coverage prior to paying for a health care service for a member, it should avoid payment by rejecting a provider's claim and direct that the provider first submit the claim to the appropriate third party. The Contractor shall be allowed to keep some or all of the costs it recovers from the third party, as set forth in Section 8.7.2 above.

When it has identified members who have health insurance, the Contractor shall validate the insurance prior to using that data for cost avoidance.

If insurance coverage information is not available, or if one of the exceptions to the cost avoidance rule discussed in this section applies, then the Contractor shall make

the payment and make a claim against the third party, if it is determined that the third party is or may be liable. The Contractor shall ensure that its cost avoidance efforts do not prevent a member from receiving medically necessary services in a timely manner.

8.7.4 Retroactive Medicare Coverage

Medicare enrollees are excluded from HIP enrollment. However, members may become retroactively Medicare eligible. When this occurs, the Contractor shall recover medical expenses payable by Medicare for the months of retroactive Medicare eligibility. The State will recoup the capitation rate paid for months with retroactive Medicare eligibility and pay a reduced dual-eligible capitation rate.

8.7.5 Cost Avoidance Exceptions

Cost avoidance exceptions in accordance with 42 CFR 433.139, which relates to third-party liability, include the following situations in which the Contractor shall first pay the provider and then coordinate with the liable third party:

- The claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program.
- The claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within thirty (30) calendar days after the date of service.
- The claim is for services provided that were covered by a third party at the time services were rendered or reimbursed (i.e., the Contractor was not aware of the third-party coverage); the Contractor shall pursue reimbursement from potentially liable third parties.

8.8 Health Information Technology and Interoperability

Contractors are required to implement and maintain systems that meet the CMS Interoperability and Patient Access requirements in 42 CFR 438.242, 42 CFR 457.1233; 42 CFR 457.760, 42 CFR 438.62, and 42 CFR 438.10 introduced in the Interoperability and Patient Access Final Rule. This includes but is not limited to patient access and provider directory Application Programming Interfaces (APIs) and payer to payer data exchanges. Contactors are also required to implement and maintain systems that meet Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B.

The Contractor must implement and maintain a publicly accessible standards-based API as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2) per 42 CFR 438.242(b)(6). In accordance with 42 CFR 438.242(b)(5) and 42 CFR 457.1233(d), the Contractor shall implement APIs that allow:

- Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;
- Encounter data, including encounter data from any network providers the Contractor is compensating on the basis of capitation payments and adjudicated

claims and encounter data from any subcontractors no later than one (1) business day after receiving the data from providers;

- Clinical data, including laboratory results, if the Contractor maintains any such data, no later than one (1) business day after the data is received by the State; and

- Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information.

Contractors should develop, implement and participate in HIT and data sharing initiatives in order to improve the quality, efficiency and safety of health care delivery in Indiana. The Contractor shall also cooperate and participate in the development and implementation of future FSSA-driven HIT initiatives.

The Contractor shall join and maintain access to the Indiana Health Information Exchange (IHIE) to enhance its capacity and effectiveness in coordinating care for members as well as drive ongoing improvement to service transparency. The State reserves the right to require the Contractor to provide updates on how the Contractor is utilizing IHIE (e.g., Admission, Discharge, and Transfer (ADT) Alerts or CareWeb for care management purposes). The State reserves the right to require the Contractor to integrate utilization of IHIE into its practices with reasonable advance notice.

In accordance with 42 CFR 438.242(b)(3)(i)-(iii), the Contractor must:

- Collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts;

- Screen the data received from providers for completeness, logic, and consistency; and

- Verify the accuracy and timeliness of data reported by providers, including data from network providers the Contractor is compensating on the basis of capitation payments.

Following are examples of HIT initiatives that the Contractor should actively be involved in, or otherwise have a plan to participate in:

8.8.1 Electronic Health Record (EHR)

An electronic health record is a digital version of a patient's paper chart that contains medical and treatment histories of patients. EHRs are real-time patient centered records that make information available instantly and securely to authorized users. They are built to share information with other health care providers and organizations in order to coordinate information for and from all clinicians involved in a patient's care such as: medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results. Appropriate technical, administrative, and physical safeguards should also be in place to protect patient health information contained in the EHR. To ensure interoperability among providers including laboratory, pharmacy, radiology, inpatient hospital/surgery center, outpatient clinical care, home health, public health and others, organizations at the national level (including the Health IT Standards Panel and the Certification Commission for Health IT) are working to develop standards related to IT

architecture, messaging, coding, and privacy/security and a certification process for technologies. The Contractor is strongly encouraged to use these standards in developing their electronic data sharing initiatives.

8.8.2 Electronic Prescribing

The ability to generate and transmit permissible prescriptions electronically. Effective August 24, 2017, Indiana began to implement a statewide, comprehensive platform for healthcare professionals to review patients' controlled-substance prescription history more quickly and efficiently. This platform supports Indiana's Prescription Drug Monitoring Program (INSPECT) and transfers data into electronic health records and pharmacy management systems. Statewide integration of the INSPECT platform is a key component of Indiana's ongoing efforts to attack the opioid crisis.

8.8.3 Inpatient computerized provider order entry (CPOE)

CPOE refers to a computer-based system of ordering diagnostic and treatment services, including laboratory, radiology and medications. A basic CPOE system promotes legible and complete order entry and can provide basic clinical decision support such as suggestions for drug doses and frequencies. More advanced CPOE systems can integrate with an EMR for access to a patient’s medical history.

8.8.4 Health information exchanges (including regional health information organizations – RHIOs)

These exchanges, such as the Indiana Health Information Exchange, allow participating providers to exchange clinical data electronically. The capacity of health information exchanges varies. Some initiatives provide electronic access only to lab or radiology results, while others offer access to shared, fully integrated medical records.

8.8.5 Benchmarking

Contractors can pool data from multiple providers and “benchmark” or compare metrics related to outcomes, utilization of services and populations. Practice pattern analysis, with appropriate risk adjustment, can help to identify differences in treatment of patients and best practices. Information can be shared with Contractors and providers to help them identify opportunities for improvement, or can be linked to pay for performance initiatives.

8.8.6 Telehealth

Telehealth allows provider-to-provider and provider-to-member live interactions, and is especially useful in situations where members do not have easy access to a provider, such as for members in rural areas. Providers also use telehealth to consult with each other and share their expertise for the benefit of treating complex patients in HIP. Contractors develop reimbursement mechanisms to encourage appropriate use of telehealth.

8.8.7 Mobile and Self-Service Technology

The Contractor is encouraged to utilize mobile and self-service technology in delivering services to members. This includes, but is not limited to, remote monitoring devices to enable members to record health measures for delivery to the Contractor and/or physician practices and medication and appointment reminders through

personalized voice or text messages.

8.8.8 Admission, Discharge, and Transfer (ADT) Alerts

ADT alerts are automatic electronic notifications of admissions, discharges, and transfers that are sent to a patient's primary care physician or other healthcare provider. Implementing ADT alerts help to reduce avoidable hospital readmissions and improves care transitions and coordination. The Contractor will promote provider utilization of ADT alerts and integrate their monitoring into health plan operations and delivery of care.

9.0 Performance Reporting and Incentives

The State places great emphasis on the delivery of quality health care to HIP members. Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered in the HIP program. The State uses various performance targets, industry standards, national benchmarks and program-specific standards in monitoring the Contractor's performance and clinical outcomes. The Contractor shall submit performance data specific to the HIP program unless otherwise specified by FSSA. The State reserves the right to publish the HIP program's performance and/or recognize the Contractor when it exceeds performance indicators. Additionally, beginning in year two (2) of the Contract, the State intends to utilize performance outcomes as a factor for auto-assignments and enrollment materials developed to facilitate member choice of an MCE.

The Contractor shall comply with all reporting requirements contained in this Contract. The Contractor shall submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the State or Secretary per 42 CFR 457.1285, 42 CFR 438.604(b), and 42 CFR 438.606. The State reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors.

The Contractor must have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to FSSA is accurate. In accordance with 42 CFR 438.604 and 42 CFR 438.606(a)-(b), all data must be certified by the Contractor's Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to one of these employees. The certification must attest, based on best knowledge, information and belief to the accuracy, completeness and truthfulness of the data and documents submitted to the State. This certification must be submitted concurrently with the certified data per 42 CFR 438.604 and 42 CFR 438.606(c). As an example only, the current Reporting Manual is provided in the Bidders' Library.

FSSA reserves the right to audit the Contractor's self-reported data and change reporting requirements at any time with reasonable notice. FSSA may require corrective actions and will assess liquidated damages, as specified in Exhibit 2.B, for Contractor non-compliance with these and other subsequent reporting requirements and performance standards. FSSA may change the frequency or content of reports and may require additional reports. FSSA shall provide at least thirty (30) calendar days' notice to the Contractor before changing reporting requirements. FSSA may request ad hoc reports at any time.

The Reporting Manual will detail reporting requirements and the full list of required reports. The Contractor shall comply with all State instructions regarding submission requirements, including but not limited to, formatting, timeliness and data uploading instructions.

FSSA may schedule meetings or conference calls with the Contractor upon receiving the performance data. When FSSA identifies potential performance issues, the Contractor must formally respond in writing to these issues within five (5) business days of the receipt of the

feedback meeting or conference call. If the Contractor fails to provide a formal, written response to the feedback or fails to respond within five (5) business days, FSSA may consider the vendor(s) noncompliant in its performance reporting and may implement corrective actions.

9.1 Administrative and Financial Reports

Financial Reports assist FSSA in monitoring the Contractor's financial trends to assess its stability and continued ability to offer health care services to its members. If the Contractor does not meet the financial reporting requirements, FSSA shall notify the Contractor of the non-compliance and designate a period of time, not less than ten (10) calendar days, during which the Contractor shall provide a written response to the notification. Contractors shall meet the IDOI licensure and financial requirements. Examples of Financial Reports to be submitted by the Contractor, in accordance with the terms of the MCE Reporting Manuals, include but are not limited to:

- IDOI Filing;
- Reimbursement for FQHC and RHC Services;
- Physician Incentive Plan Disclosure;
- Encounter Data Quality Validation template;
- Insurance Premium Notice;
- Capitation Reconciliation Report;
- Vendor Contact Sheet;
- Key Staff and Other Staffing; and
- Audited Financial Report.

On an annual basis and in accordance with 42 CFR 438.3(m), the Contractor must submit program specific audited financial reports, separate for each managed care program (i.e., HIP, Hoosier Healthwise, and Hoosier Care Connect as applicable). The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. The audit must detail the medical expense payments reported net of subcontracted administrative expenses and categorize all quality improvement spending into the allowed five categories. The audit shall review if quality improvement spending passes the requirements under 45 CFR 158.150(b). Audits should be performed for calendar years using data on a services-incurred basis.

9.2 Member Service Reports

Member Service Reports identify the methods the Contractor uses to communicate to members about preventive health care and program services and monitor member satisfaction.

FSSA reserves the right to require more frequent Member Service reporting at the beginning of the Contract and as necessary to ensure satisfactory levels of member service.

9.3 Network Development Reports

Network Development Reports assist FSSA in monitoring the Contractor's network composition by specialty and geo-access ratios in order to assess member access and network capacity. The Contractor shall identify current enrollment, gaps in network services and the corrective actions that the Contractor is taking to resolve any potential problems relating to network access and capacity.

FSSA will require more frequent Network Geographic Access Assessment reporting at the beginning of the Contract and during implementation of program changes as necessary to

ensure satisfactory network access, until the Contractor demonstrates that the network access standards have been met.

9.4 Provider Service Reports

Provider Service Reports assist FSSA in monitoring the methods the Contractor uses to communicate to providers about clinical, technical and quality management and improvement issues relating to the program.

9.5 Quality Management Reports

Quality Management Reports document the methods and processes the Contractor uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports assist FSSA in monitoring the Contractor's quality management and improvement activities.

9.6 Utilization Reports

Utilization Reports assist FSSA in monitoring the Contractor's utilization trends to assess its stability and continued ability to offer health care services to its members.

9.7 Claims Reports

These reports assist FSSA in monitoring the Contractor's claims processing activities to ensure appropriate member access to services and payments to providers. The Contractor shall submit claims processing and adjudication data. The Contractor shall also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing.

9.8 HIP Reports

Due to HIP's unique program design, the Contractor shall also be required to provide the reports specific to its HIP line of business. Examples of HIP Reports to be submitted by the Contractor, in accordance with the terms of the HIP MCE Reporting Manual, include but are not limited to:

- POWER Account Summary;
- Benefit Design Summary, including benefit plan transfer data;
- Preventive Care Report;
- Rollover Report;
- Pregnancy Identification Report;
- Medically Frail Identification Report; and
- Tobacco Surcharge Report.

The Contractor shall be prepared to break out HIP data (such as enrollment data, non-payment of POWER Account contribution data and other POWER Account data) in a manner requested by the State according to various member characteristics, including, but not limited to HIP benefit package, medically frail status, and/or FPL category.

9.9 CMS Reporting

The Contractor shall be required to submit data requested by the Centers for Medicare and Medicaid Services (CMS), including but not limited to all required MCE reporting obligations

described in the CMS Special Terms and Conditions (STCs) for the State's waiver. For example, in addition to the specific reports described in the STCs, CMS often requests additional data and reports in advance of FSSA's monthly conference calls with CMS. In preparation for these calls, FSSA will ask the Contractor for data requested by CMS. The Contractor shall submit this data in the timeframe specified by FSSA.

In addition, the Contractor shall cooperate with FSSA in meeting all other CMS required HIP reporting activities, whether specifically set forth in the CMS STCs for the State's waiver, or as otherwise requested by CMS. The Contractor agrees to submit data for the HIP quarterly and annual reports to FSSA in a timeframe and format as requested by FSSA, as set forth in the HIP MCE Reporting Manual. For any reports not specifically set forth in the HIP MCE Reporting Manual, the State will submit any such reporting and data requests directly to the Contractor's Compliance Officer.

9.10 Unclaimed Refunds or Property Report

The Contractor shall document all unclaimed refunds and property on a monthly basis and submit this information to the Indiana Attorney General's Office. Unclaimed refunds should include all checks that are refunds due to a member or checks written to a provider (i.e., "expenditure payouts," etc.) that for whatever reason are not cashed by the member or provider. If no refunds were submitted during a period, the report must be submitted indicating "No Refunds Submitted to the Attorney General During This Month." The Contractor is responsible for assuring that all of its subcontractors/vendors submit the same reports monthly or that Contractor's report captures the relevant information from subcontractors/vendors.

9.11 Other Reporting

OMPP shall have the right to require additional reports to address program-related issues that are not anticipated at the Contract start date but are determined by FSSA to be necessary for program monitoring.

10.0 Failure to Perform/Non-compliance Remedies

10.1 Non-compliance Remedies

It is the State's primary goal to ensure that the Contractor is delivering quality care to members. To assess attainment of this goal, the State monitors certain quality and performance standards, and holds the Contractor accountable for being in compliance with Contract terms at all terms. FSSA will work collaboratively with the Contractor to maintain and improve programs, and not to impair health plan stability.

In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Exhibit 2.B, or the Contractor Reporting Manual, the State will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies set forth in Exhibit 2.B. The State will provide written notice of non- compliance to the Contractor within sixty (60) calendar days of the State's discovery of such non-compliance.

Notwithstanding the foregoing, any failure or delay on the part of the State in providing written notice or otherwise exercising any right, power or remedy under the Contract will not operate as a waiver of such right, power or remedy, and no single or partial exercise of any such right, power, or remedy will preclude any other or further exercise of such right, power or remedy. Except as specifically set forth herein, the rights and remedies available pursuant to this Contract are cumulative in nature and not alternative. For example, if FSSA

elects not to exercise a corrective action clause contained anywhere in the Contract in a particular instance, this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the Contract, may be retroactively assessed.

10.2 Evidence of Financial Responsibility

The State reserves the right to require a performance bond of standard commercial scope issued by a surety company registered with the IDOI or other evidence of financial responsibility to guarantee performance by the Contractor of its obligations under the Contract.

The State reserves the right to implement financial responsibility requirements if enrollment levels indicate the need to do so. If these requirements are implemented and default by the Contractor occurs, the State shall, in addition to any other remedies it may have under the Contract, obtain payment under the performance bond or other arrangement for the purposes of the following:

- Reimbursing the State for any expenses incurred by reason of a breach of the Contractor's obligations under the Contract, including, but not limited to, expenses incurred after termination of the Contract for reasons other than the convenience of the State.

- Reimbursing the State for costs incurred in procuring replacement services.

11.0 Termination Provisions

11.1 Contract Terminations

FSSA shall have the right to terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any substantive term or condition of the Contract, failure to meet the applicable requirements of sections 1932, 1903(m), or 1905(t) of the Social Security Act or take corrective action as required by FSSA to comply with the terms of the Contract. In the event the State terminates the Contract, members will be placed into a different health plan or be provided Medicaid benefits through other State Plan authority in accordance with 42 CFR 438.708, sections 1903(m), 1905(t) and 1932 of the Social Security Act. The Contract between the parties may be terminated on the following basis listed below:

- By the Contractor, subject to the remedies listed in the Contract.

- By the State, in whole or in part, whenever the State determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within thirty (30) calendar days after receipt of a notice specifying those conditions.

- By the State, in whole or in part, whenever, for any reason, the State determines that such termination is in the best interest of the State, with at least thirty (30) calendar days' prior notice to the Contractor. Such termination is referred to herein as "Termination for Convenience."

- By the State, in whole or in part, whenever funding from state, federal or other sources are withdrawn, reduced or limited, with sufficient prior notice to the Contractor.

- By the State, in whole or in part, whenever the State determines that the instability of the Contractor's financial condition threatens delivery of Medicaid services and continued performance of Contractor responsibilities.

The State will provide the Contractor with a pre-termination hearing prior to contract termination in accordance with 42 CFR 438.708 and 42 CFR 438.710(b). In accordance with 42 CFR 438.710(b)(2), 42 CFR 438.722, section 1932(e)(4) of the Social Security Act and 42 CFR 438.10, the State will:

- Give the Contractor a written notice of its intent to terminate and the reason for the termination;
- Provide the Contractor with the time and place of the pre-termination hearing;
- Provide the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract;
- Provide the effective date for Contract termination when decisions are affirmed;
- Give the enrollees of the Contractor notice of the State's intent and actual termination; and
- Inform enrollees of their options to disenroll immediately without cause and for receiving Medicaid services following the effective dates of termination.

11.1.1 Termination by the State for Contractor Default

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor or a subcontractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within thirty (30) calendar days, or such other reasonable period of time as specified in writing by the State, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the State that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the State will notify the Contractor that the Contract, in full or in part, has been terminated for default.

If, after notice of termination for default, it is determined by the State or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a Termination for Convenience, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided under this clause, the State may procure, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and the

Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the State for costs incurred to procure such similar supplies or services as are needed to continue operations.

In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined in the Contract.

In the event of a termination for default during ongoing operations, the Contractor will be paid for any outstanding capitation payments due, less any assessed damages.

In accordance with 42 CFR 438.700(b), 42 CFR 438.726(b), 42 CFR 438.730(e)(1)(i), and section 1903(m)(5)(B)(ii) of the Social Security Act, the State will deny payments for new enrollees when, and for so long as, payment for those enrollees is denied by CMS based on the State's recommendation, when:

- The Contractor fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Contract with the State, to an enrollee covered under the Contract.
- The Contractor imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- The Contractor acts to discriminate among enrollees on the basis of their health status or need for health care services.
- The Contractor misrepresents or falsifies information that it furnishes to CMS or to the State.
- The Contractor misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- The Contractor fails to comply with the requirements for QIPs, as set forth (for Medicare) in 42 CFR 422.208 and 42 CFR 422.210.

The State will deny payments for new enrollees when, and for so long as, payment for those enrollees is denied by CMS. CMS may deny payment to the State for new enrollees if its determination is not timely contested by the Contractor per 42 CFR 438.726(b) and 42 CFR 438.730(e)(1)(ii).

The rights and remedies of the State provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

11.1.2 Termination for Financial Instability

FSSA may terminate the Contract immediately upon the occurrence of any of the following events:

- The Contractor becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under the Contract;
- The Contractor ceases to conduct business in normal course;
- The Contractor makes a general assignment for the benefit of creditors; or

- The Contractor suffers or permits the appointment of a receiver for its business or assets.

The State may, at its option, immediately terminate the Contract effective at the close of business on the date specified. In the event the State elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor shall immediately advise the Contract Administrator as specified in the Contract between the State and the Contractor. The Contractor shall ensure that all tasks related to the subcontract are performed in accordance with the terms of the Contract.

11.1.3 Termination for Failure to Disclose Records

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor has failed to make available to any authorized representative of the State, any administrative, financial and medical records relating to the delivery of services for which state Medicaid and/or CHIP program dollars have been expended.

In the event that the State terminates the Contract pursuant to this provision, the Contractor shall be notified in writing, either by certified or registered mail, either sixty (60) calendar days prior to or such other reasonable period of time prior to the effective date, of the basis and extent of the termination. Termination shall be effective as of the close of business on the date specified in the notice.

11.1.4 Termination by the Contractor

The Contractor shall give advance written notice of termination, or intent not to renew, to the State a minimum of one hundred and eighty (180) calendar days prior to termination. The effective date of the termination shall be no earlier than the last day of the month in which the one hundred and eightieth (180th) day falls. Termination of the Contract by the Contractor is subject to damages listed in Section 11.4.

11.2 Termination Procedures

When termination is anticipated, FSSA shall deliver to the Contractor written notice of termination by certified or registered mail specifying the nature of the termination and the date upon which such termination becomes effective ("Notice of Termination"). Within ten (10) calendar days of receipt of the Notice of Termination, the Contractor shall develop and submit a written plan to termination ("Transition Plan") for FSSA's approval. The Transition Plan shall, at minimum address the following:

- Stopping work under the Contract, on the date and to the extent specified in the Notice of Termination.
- Placing no further orders or subcontracts for materials, services or facilities.
- Notifying all of the Contractor's members regarding the date of termination and the process by which members will continue to receive medical care. For its HIP members, the Contractor shall also explain how they will have access to POWER Account funds. FSSA must approve all member notification materials in advance of distribution.

- Terminating all orders and subcontracts, to the extent that they relate to the performance of work terminated by the Notice of Termination.

- Assigning activities to the State, its designee or successor contractor, in the manner and to the extent that they relate to the performance of work terminated by the Notice of Termination.

- Assigning to the State, its designee or successor MCE, in the manner and to the extent directed, all of the rights, titles and interests of the Contractor under the orders or subcontracts so terminated.

- With the approval of the State, settling outstanding liabilities and all claims arising out of such termination of orders and subcontracts.

- With the approval of the State, establishing a plan for transferring member POWER Account funds and related information to the State, its designee or the successor MCE.

- Within ten (10) business days from the effective date of the termination, transferring title to the State of Indiana (to the extent that title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information and documentation, in any form that relates to the work terminated by the Notice of Termination.

- Completing the performance of such part of work that has not been specified for termination by the Notice of Termination.

- Taking such action as may be necessary, or as the State may direct, for the protection and preservation of the property related to the Contract that is in the possession of the Contractor and in which the State has or may acquire an interest.

- Providing for all the Contractor's responsibilities set forth in Section 11.3 below.

The requirements listed above are illustrative only and do not limit or restrict the State's ability to require the Contractor to address additional issues in its Transition Plan.

The State shall withhold the Contractor's final capitation payment until the Contractor has 1) received FSSA approval of its Transition Plan and 2) completed the activities set forth in its Transition Plan, as well as any additional activities requested by FSSA, to the satisfaction of FSSA. Satisfactory completion of the Contractor's transition responsibilities pursuant to the FSSA-approved Transition Plan shall be made at the sole discretion of FSSA.

11.3 Contractor Responsibilities Upon Termination or Expiration of the Contract

Termination or expiration of the Contract does not discharge the obligations of the Contractor with respect to services or items furnished prior to termination or expiration of the Contract, including retention of records and verification of overpayments or underpayments. Termination or expiration of the Contract does not discharge the State's payment obligations to the Contractor or the Contractor's payment obligations to its subcontractors and providers. Upon termination or expiration of the Contract, the Contractor shall:

- Assist the State in taking the necessary steps to ensure a smooth transition of

services after expiration or termination of the Contract.

- Provide a written Transition Plan for the State's approval in accordance with Section 11.2. In the event of Contract termination, the Transition Plan shall be due within ten (10) calendar days of receiving Notice of Termination from the State. In the event of Contract expiration, the Transition Plan shall be due at least one hundred and eighty (180) calendar days prior to expiration of the Contract. The Contractor will revise and resubmit the Transition Plan to the State on a regular basis, the frequency of which will be determined by the State.

- Appoint a liaison for post-transition concerns.

- Provide for sufficient claims payment staff, member services staff, POWER Account staff and provider services staff to ensure a smooth transition.

- Provide the State with all information requested by the State in the format and within the timeframes set forth by the State, which shall be no later than thirty (30) calendar days of the request, including for HIP members up-to-date data about POWER Account balances, annual and lifetime benefit totals and member utilization of recommended preventive services.

- Assist the State and/or its subcontractors in FQHC/RHC settlement process for settlement periods prior to the day of termination or expiration of the Contract. Requested assistance may include but is not limited to data support for questions regarding FQHC/RHC claims data and reports and the submission of claims data files to the State and/or its vendors.

- Be financially responsible for all claims with dates of service through the day of termination or expiration of the Contract, including those submitted within established time limits after the day of termination or expiration of the Contract.

- Be responsible for submitting encounter data to the State for all claims incurred prior to the contract expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after termination or expiration of the Contract.

- Be responsible for submitting all performance data with a due date following the termination or expiration of the Contract, but covering a reporting period prior to termination or expiration of the Contract, including but not limited to CAHPS, HEDIS, Reimbursement for FQHC and RHC Services and the Capitation Rate Calculation Sheet.

- Be responsible for resolving member grievances and appeals with respect to claims with dates of service prior to the day of contract expiration, including grievances and appeals filed on or after the day of Contract termination or expiration but with dates of service prior to the day of Contract termination or expiration.

- Be financially responsible for inpatient services for patients hospitalized on or before the day of Contract termination or expiration through the date of discharge, including the DRG payment and any outlier payments.

- Be financially responsible for services rendered through the day of termination or expiration of the Contract, for which payment is denied by the Contractor and

subsequently approved upon appeal by the provider.

- Be financially responsible for member appeals of adverse decisions rendered by the Contractor concerning treatment of services requested prior to termination or expiration of the Contract which are subsequently upheld on behalf of the member after an appeal proceeding or after a FSSA Fair Hearing.

- Arrange for the orderly transfer of patient care and patient records to those providers who will assume care for the member. For those members in a course of treatment for which a change of providers could be harmful, the Contractor shall continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged. The Contractor shall transfer all applicable clinical information on file, including but not limited to approved and outstanding prior authorization requests and a list of members in case or care management, to the State and/or the successor MCE at least fourteen (14) calendar days prior to the day of termination or expiration of the Contract. A final file shall be provided within five (5) business days of the termination or expiration of the Contract.

  Notify all members about the Contract termination and the process by which members will continue to make POWER Account contribution payment, and receive medical care, at least sixty (60) calendar days in advance of the effective date of termination or Contract expiration. For its HIP members, the Contractor shall also explain how they will have access to POWER Account funds. The Contractor will be responsible for all expenses associated with member notification. FSSA shall approve all member notification materials in advance of distribution.

- Notify all providers about the Contract termination and the process by which members will continue to receive medical care, at least sixty (60) calendar days in advance of the effective day of termination or expiration of the Contract. The Contractor will be responsible for all expenses associated with provider notification. FSSA shall approve all provider notification materials in advance of distribution.

- Report any capitation or other overpayments made by the State to the Contractor within thirty (30) calendar days of discovery and cooperate with investigations by the State or its subcontractors into possible overpayments made during the contract term. The Contractor shall return any capitation or other overpayments, including those discovered after contract expiration, to the State within fourteen (14) calendar days of reporting the overpayment to the State.

- Coordinate the continuation of care for members who are undergoing treatment for an acute condition.

- Be responsible to submit the HEDIS Auditor Report listed in Section 9.0, in accordance with the applicable due date, and to participate in the External Quality Review, as required by 42 CFR 438, Subpart E, for the final year of the Contract.

- The State, CMS, the OIG, the Comptroller General, and their designees have the right to audit records or documents of the Contractor and their subcontractors for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later, per 42 CFR 438.3(h).

- Comply with any additional items the State required the Contractor to address in its Transition Plan.

The State shall have the right to withhold some or all retroactive capitation adjustment payments due and owing to the Contract in the event the Contractor fails to comply with the responsibilities set forth in this section, including its responsibilities related to data submission and support.

11.4 Damages

The Contractor acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State, which may not be adequately compensable in damages. The Contractor acknowledges that the State has incurred substantial expenses in connection with the preparation and entry into the Contract, including expenses relating to training staff, data collection and processing, actuarial determination of capitation rates, and ongoing changes to the State's and its fiscal agent's management information systems. The Contractor further acknowledges and agrees that in the event the Contract is terminated prior to the end of the initial term or any renewal term, due to the actions of the Contractor or due to the Contractor's failure to fully comply with the terms and conditions of the Contract, the State will incur substantial additional expense in processing the disenrollment of all members and the related MIS changes, in effecting staffing changes, in procuring alternative health care arrangements for members, and in other areas unknown to the State at this time. The Contractor accordingly agrees that the State may, in such event, seek and obtain actual damages.

The remedies available to the State under this Agreement include but are not limited to:

- Obtaining payment under the performance bond or other arrangement set forth in Section 10.2; and

- Assessing actual damages measured by the cost to the State to transition members to other providers and/or another Contractor. This includes, but is not limited to, payments the State may make to other contractors to perform work related to the transition.

Payment of the performance bond or other arrangement established under Section 10.2 is due within ten (10) calendar days of the date of termination. Payment of liquidated damages is due within thirty (30) calendar days from the date of termination. Payment of actual damages is due within ten (10) calendar days of the Contractor's receipt of the State's demand for payment.

11.5 Assignment of Terminating Contractor's Membership and Responsibilities

If the Contract is terminated for any reason, the State may assign the Contractor's membership and responsibilities to one or more other MCEs who also provide services to and HIP populations, subject to consent by the MCE that would gain the member enrollment.

In the event that FSSA assigns members or responsibility to another MCE, during the final quarter of the Contract, the Contractor will work cooperatively with, and supply program information to, any successor MCEs. Both the program information and the working relationship among the Contractor and successor MCEs will be defined by the State.

11.6 Refunds of Advanced Payments

The Contractor shall, within thirty (30) calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the Contract.

11.7 Termination Claims

If the Contract is terminated under this section, the Contractor shall be entitled to be paid a prorated capitation amount, determined by the State based on available information, for the month in which notice of termination was received for the service days prior to the effective date of termination. The Contractor will have the right of appeal, as stated under the subsection on Disputes in the Contract, of any such determination. The Contractor will not be entitled to payment of any services performed after the effective date of termination.

12.0 HIP Plan Design and Member Eligibility

The Contractor shall provide all HIP members with a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account. The Power Account operates similarly to a Health Savings Account (HSA), and is used to fund a $2,500 deductible, as more fully described in Section 14.0 below. The Contractor's HIP membership shall be distributed into various subpopulations based on member eligibility. These subpopulations within HIP will have varying benefits and cost-sharing obligations, and the Contractor shall ensure that its HIP members are placed in the appropriate benefit category, in accordance with the eligibility standards set forth in this Section 12.0, as well as the additional policies and procedures included in the HIP MCE Policies and Procedures Manual. The Contractor is responsible for ensuring seamless transitions between benefit plans as member eligibility changes, as detailed in Section 3.13. A general description of all HIP benefits is in Section 3. The State reserves the right to modify HIP plan design, including cost-sharing and eligibility components, in accordance with federal and State guidance.

12.1 HIP Plus

Except in the case of individuals eligible for HIP State Plan benefits described in Section 12.3, all HIP eligible members will initially be defaulted into an enhanced benefit package (HIP Plus). Except for individuals exempt from copayments as set forth in Section 13.1.4, HIP Plus participation requires members to make monthly POWER Account contributions. Member eligibility in HIP Plus shall not be final until either the first POWER Account contribution or fast track prepayment contribution is paid, in accordance with Section 13.7. Except as set forth in Section 13.7.1, to remain eligible for HIP Plus, members shall continually make monthly POWER Account contributions as set forth in Section 13.1.1.

12.1.1 Low Income Adults

Parent/caretaker members determined eligible for transitional medical assistance (TMA) by the State in accordance with Section 1925 of the Social Security Act shall either attain or remain in HIP Plus coverage for up to twelve (12) months during their TMA eligibility period. If after the first six (6) months of TMA coverage income remains over 138% but below 185% FPL, coverage can extend an additional six (6) months as long as POWER Account contributions are paid. The State will identify all members eligible for HIP Plus benefits that meet the eligibility criteria of this Section 12.1.1.

12.2 HIP Basic

HIP members with income at or below one hundred percent (100%) FPL who do not make either their fast-track prepayment, initial or subsequent POWER Account contributions as required by Section 13.1.1 will not be eligible for HIP Plus, and will be transferred to a more limited benefit package, which requires copayments for services as set forth in Section 13.1.2 (HIP Basic).

12.2.1 HIP Basic Potential Plus

If a member is determined to now be eligible for HIP Plus, they will be assigned to the Basic benefit package called HIP Basic Potential Plus. This could apply to a member who had other IHCP coverage and transitioned into the HIP program or a member who has earned rollover as a result of the POWER Account reconciliation process. The member will remain in Potential Plus status until the first POWER Account contribution or the fast-track payment is made. The member has sixty (60) days to make a payment and move to HIP Plus.

Once the Contractor receives the POWER Account contribution, they will notify the state via the payday file submitted to *Core*MMIS. Once the member's payment is applied, they will be moved to HIP Plus and the Contractor will be notified via the 834 of the benefit plan change.

12.2.2 Low Income Adults

Individuals referenced under 12.1.1 may default to HIP Basic benefits in the first six months of TMA coverage for failure to pay. Individuals referenced in 12.1.1 are not eligible for TMA after the second six months of coverage.

12.3 HIP State Plan

The Contractor shall provide HIP State Plan benefits to HIP members meeting any of the eligibility criteria listed in this Section 12.3. Unless otherwise exempt from cost-sharing as set forth in Section 13.1.4, all members receiving HIP State Plan benefits will either pay monthly POWER Account contributions consistent with the HIP Plus plan as set forth in Section 13.1.1 (HIP State Plan Plus) or, if at or below 100% FPL or other eligible for HIP State Plan Basic pursuant to Section 13.7.2., pay copayments for services as required under the HIP Basic plan as set forth in Section 13.1.2 (HIP State Plan Basic).

12.3.1 Low Income Adults

Section 1931 eligible parents and caretaker relatives eligible under 42 CFR 435.110, shall receive HIP State Plan benefits.

12.3.2 Medically Frail

The Contractor shall provide HIP State Plan services to members who meet the definition of medically frail. Consistent with 42 CFR 440.315(f), an individual will be considered medically frail if he or she has one or more of the following:

- Disabling mental disorder;
- A chronic substance abuse disorder;
- Serious and complex medical conditions;
- Physical, intellectual, or developmental disability that significantly impair the individuals' ability to perform one or more activities of daily living; or
- A disability determination based on Social Security Administration criteria.

12.3.2.1 State Identification of Medically Frail

Eligible members with a disability determination based on Social Security Administration criteria are automatically confirmed medically frail by the State, and the Contractor will not be responsible for verifying the medically frail designation.

Eligible members who have been confirmed HIV positive and identified to the State by the Indiana Department of Health will be automatically confirmed medically frail by the State, the Contractor will not be responsible for verifying the medically frail designation.

12.3.2.2 Medically Frail Determination

The Contractor shall utilize the Milliman Medical Underwriting Guidelines ("Milliman Guidelines") to determine a medically frail designation, a HIP member may be designated as medically frail at any time during the member's twelve (12) month benefit period, provided such designation is supported by the Milliman Guidelines.

In accordance with Section 3.8.1, the Contractor shall conduct an initial health needs screening of all new members within ninety (90) calendar days of a new member's enrollment in the Contractor's plan. The initial health needs screening shall be followed by a detailed comprehensive health assessment conducted by a health care professional in order to gather applicable information to compare against the Medical Underwriting Guidelines. The comprehensive health assessment may include a full review of important relevant clinical information such as the provider's assessment of conditions and the severity of illness, treatment history and outcomes, other diseases, illnesses, and health conditions as well a review of the member's available claims, including pharmacy claims.

The Contractors shall apply the Milliman Guidelines to either the information obtained in the initial health needs screening and comprehensive health assessment, or the member's claims history to generate debit points for the member. The member would qualify as medically frail based on the member's qualifying conditions and related risk scores as follows:

- 150 debit points for indicated medical conditions;
- 150 debit points for combined indicated medical, behavioral health and substance abuse conditions;
- 75 debit points for indicated behavioral health conditions;
- 75 debit points for indicated substance abuse conditions; or
- Needs assistances with one of the activities of daily living.

Either the member, provider or the Contractor may initiate a medically frail assessment during the member's benefit period. The Contractor shall establish a process to allow members to self-identify as medically frail to the Contractor. If requested by the member, the Contractor shall conduct a medically frail assessment in accordance with this Section 12.3.2.2 within

thirty (30) days of the member's self-identification.

If the results of applying the Milliman Guidelines supports a medically frail designation, the Contractor shall document and support the decision. Documentation may include, but is not limited to (i) output files from the Milliman Renewal MUGs tool indicating the number of debit points the member accumulated; (ii) completed comprehensive health assessment tool; (iii) documentation of attempts to make contact with their member and/or physician(s); (iv) recorded responses and supporting information indicating member impairment in Activities of Daily Living (ADLs); (v) supplemental information gathered by the Contractor in order to make a complete decision (such as lab results, physician notes or lifestyle factors).

The Contractor shall notify the State's fiscal agent in the manner and timeframe determined by the State and established in the HIP MCE Policies and Procedures Manual when a HIP member is determined medically frail by the Contractor.

Upon receipt of the medically frail confirmation, the State will transfer the member to HIP State Plan benefits effective the first day of the month following receipt of the medically frail confirmation. If, following a medical frail assessment, the results of the claims history and/or pharmacy data review do not support a medically frail designation, the Contractor shall inform the member that they will remain in their current HIP benefit plan.

The Contractor is responsible for notifying the member of the ultimate medically frail designation decision, any changes to the member's benefits, as well as the member's right to appeal in accordance with Section 4.9.

12.3.2.3 Medically Frail Annual Review

The Contractor shall maintain documentation that every medically frail member meets specific medically frail criteria, as set forth by FSSA, for receipt of HIP State Plan benefits. The Contractor shall confirm a member's status as medically frail at least annually, except for those members mentioned in 12.3.2.1, from the member's most recent medically frail determination in accordance with a process as determined by FSSA. At minimum, the Contractor shall affirm the medically frail designation by conducting an annual review of the member's claim history and/ or pharmacy data against the Milliman Guidelines.

Following the completion of the annual medically frail confirmation, the Contractor shall notify the State's fiscal agent of the results no later than fifteen (15) calendar days prior to the one-year anniversary of the Contractor's previous medically frail determination or confirmation, as applicable. If a member is determined no longer to be medically frail, the member will be transferred to either (i) HIP Plus if they are currently making the required POWER account contributions, or are otherwise over 100% FPL, or (ii) HIP Basic if they are currently paying copayments at the time of service and under 100% FPL.

12.3.2.4 State Audit

The State will conduct regular audits of the Contractor's Medically Frail assessment and confirmation process pursuant to Section 12.3.2.2, to

determine appropriate identification and placement of medically frail members. The State anticipates that less than ten percent (10%) of the Contractor's total newly eligible adult HIP population will be designated as medically frail. The Contractor shall consistently apply the Milliman Guidelines to every medically frail determination and review.

12.4 Pregnancy Coverage under HIP

HIP members who become pregnant will receive maternity benefits through the HIP Maternity (MAMA eligibility aid category) benefit plan. The HIP Maternity benefits are equivalent to HIP State Plan. Applicants with income at or below 138% FPL who are pregnant will be enrolled in the HIP Maternity program. Members will not change programs during pregnancy, twelve (12) months postpartum or at their eligibility redetermination, pursuant to the federal provision in the American Rescue Plan Act of 2021 (HR 1319). The member will be moved into the MAMA aid category on the first day of the month following the month in which the State becomes aware a member is pregnant. The Contractor will not move the member into HIP Maternity for past months, only future months.

The Contractor shall develop and maintain policies and procedures for quickly identifying pregnant HIP members. The Contractor shall notify the State's fiscal agent within one (1) business day of confirming a member's pregnancy. The notice shall include the pregnancy start date as well as the expected delivery date. Date of confirmation for purposes of this Section 12.4 shall mean the date the Contractor receives notification of member pregnancy from the provider, whether through the official NOP form described in Section 6.2.3 or otherwise. In the event the Contractor discovers member pregnancy prior to provider confirmation, such as through claims data, the Contractor shall confirm member pregnancy with the provider within three (3) business days of discovery, provided the member has engaged with a provider.

Pregnant members shall not be subject to any cost sharing. Once pregnancy has been confirmed, and following notification from the State, the Contractor shall suspend the member's POWER Account and all member cost-sharing, including POWER Account contributions and/or copayments, as applicable, effective the first day of the month following the notification from the State. Pregnancy notifications received by the State less than six (6) business days prior to the end of the month will be processed to be effective the first day of the subsequent month. Notwithstanding the foregoing, at no time shall claims with a diagnosis of pregnancy be subject to member cost-sharing. The Contractor is responsible for reporting that members who become pregnant are exempt from cost-sharing via the supplemental file when they report the member's pregnancy. The Contractor shall have policies and procedures in place for quickly identifying pregnant members and suspending all cost-sharing.

The Contractor is responsible for informing the member of their HIP Maternity coverage. This information shall, at minimum, be included in the Contractor's Member Handbook, as described in Section 4.4.3. The Contractor shall also work closely with its providers to complete the Notification of Pregnancy risk assessment on all pregnant members, as detailed in Section 6.2.3.

The Contractor shall notify the State's fiscal agent within one (1) business day of discovering the date of the end of the pregnancy. The submission of the supplemental file indicating that a member delivery has occurred generates a maternity delivery capitation payment for HIP members. Refer to the HIP MCE Policies and Procedures Manual for specific information.

HIP Maternity benefits will end on the first of the month after the twelve (12) month post-

partum period, pursuant to the federal provision in the American Rescue Plan Act of 2021 (HR 1319). The Contractor will provide pregnancy, post-partum, and HIP benefits aligned with the dates and benefits specified on the 834. The Contractor shall communicate regularly with the member during the post-partum period. Additional guidelines regarding the Contractor's responsibility to assist pregnant members obtain and maintain coverage are located in the HIP MCE Policies and Procedures Manual.

As members transition from HIP Maternity following the twelve (12) month post-partum period, their POWER Account and cost sharing will begin and they will be assigned to the HIP Basic Potential Plus category. They will have sixty (60) days to make the first POWER Account contribution in order to move to the HIP Plus benefit category. The Contractor is responsible for informing the member of the change from HIP Maternity to the HIP Basic Potential Plus category and the method for the member to obtain HIP Plus benefits.

When a member enrolls in HIP Maternity in her third trimester of pregnancy, the Contractor shall honor the member's request to continue to receive maternity care from her current physician and reimburse for covered services provided to the member by her current physician, regardless of whether the physician is in the Contractor's network.

Policies, procedures and POWER Account technical requirements related to pregnancy are documented in the HIP MCE Policies and Procedures Manual. The Contractor shall be required to comply with the requirements set forth in these documents as of the effective date of the Contract.

13.0 Billing and Collections

Except for members exempt from cost sharing pursuant to Section 13.1.4, all HIP members are responsible for making financial contributions to their health care coverage, either through regular POWER Account contributions or HIP Basic copayments for services. The Contractor shall be responsible for billing, collecting and applying applicable POWER Account contributions for members receiving HIP Plus or HIP State Plan Plus benefits. The State reserves the right to modify HIP plan design, including cost-sharing and eligibility components, in accordance with federal and State guidance.

Collection services shall include:

- Creating and maintaining HIPAA compliant POWER Account contribution billing services;
- Generating and mailing invoices, although members may opt-in to receiving electronic invoices;
- Receiving and posting payments;
- Monitoring and tracking missed payments;
- Processing returned checks;
- Stopping or placing collections on hold as directed by the State;
- Generating past due notices and other notifications;
- Generating other informational materials as requested by the State;
- Providing documentation of account activities and other financial reports;

- Processing and mailing fast track prepayment and/or POWER Account contribution refunds;
- Transferring collected funds as requested by the State;
- Documentation and reconciliation of funds received and transferred;
- Establishing and handling a lockbox for HIP payments;
- Providing services online that support and interface with the State's current website;
- Ensuring the integrity and accuracy of data exchanged with or provided to the State, and that the data is compatible with other software, hardware or systems used by the State;
- Ensuring compliance with current bankruptcy rules, the Cash Management Improvement Act of 1990 guidelines (Public Law 101-453), confidential information and electronic transaction processing procedures;
- Adhering to established health care industry standards, in addition to any Medicaid rules, regulations and or mandates, as well as amendments thereto;
- Date stamping mail received; and
- Forwarding all change of address notifications and mail returned as undeliverable as specified by the State.

Additionally, while the Contractor is not required to promote cash payment by mail as a payment option, the Contractor shall be equipped to accept cash payments, including cash payment by mail, if submitted by the member. Further, the State encourages arrangements with local entities to facilitate the collection of contributions, including no-cost options for collecting cash contributions. In addition, the State will assist the Contractor by identifying vendor(s) that can accept cash contributions. The Contractor agrees to use commercially reasonable efforts to work with such vendor(s) to accept cash contributions at no cost to the member. The Contractor shall ensure that any cash contributions collected by third party vendors in accordance with this section are credited toward the member's POWER Account within two (2) business days. More information about preferred vendor(s) and cash collection methods may be found in the HIP MCE Policies and Procedures Manual.

The State will determine the member's required POWER Account contribution amounts during the application process and will notify the Contractor of these amounts. The required POWER Account contribution will be provided to the Contractor in both an annual benefit period amount and a monthly billing amount. POWER Account contributions will be recalculated by the State during eligibility redetermination, and as otherwise required throughout the benefit period based on member reported changes, in accordance with Section 13.4 below.

13.1 Individual Cost-Sharing Obligations

As detailed in Section 3.16, the Contractor shall ensure that member cost sharing as set forth in this Section 13.1 does not exceed five percent (5%) of family income as calculated on a quarterly basis, except that all HIP Plus or HIP State Plan Plus members whose household income is at or below five percent (5%) of the FPL will be required to contribute, at a minimum, monthly one dollar ($1.00) POWER account contributions. The Contractor will work with the State to consider all contributions made by the household in the calculation and monitoring of the 5% contribution limit. The Contractor will have the ability

to identify members who have reached the maximum contribution and to cease that member's cost sharing obligations in accordance with the HIP MCE Policies and Procedure Manual. While the Contractor has the primary responsibility for tracking member's cost sharing, the Contractor shall also have a process in place that allows a member to self-report on their expenditures and have a process in place to end cost sharing based on member provided documentation.

In addition to the cost-sharing set forth below, all HIP members (with the exception of members exempt from cost-sharing as described in Section 13.1.4) will be required to make an $8.00 copayment for non-emergent use of hospital emergency departments, as further described in Section 3.6.2.

13.1.1 HIP Plus Member Cost-Sharing

In order to participate in HIP Plus or HIP State Plan Plus, members are required to help fund their $2,500 deductible by contributing to their POWER Account on a monthly basis. Required contributions will be calculated based on a tiered contribution structure. The tier contribution structure assigns a specific POWER Account contribution amount, roughly equivalent to 2% of income, based on the member's FPL. For married couples participating in HIP Plus, the State will divide the monthly contribution between the two HIP eligible married adults, and each member will be responsible for half of the calculated amount on a monthly basis. Individuals who have indicated they are tobacco users will be required to pay an increased contribution amount beginning in the second calendar year benefit period as part of the tiered structure. In no event will a member's base monthly POWER account contribution be less than one dollar ($1.00).

Base HIP Plus member required contribution tiers based on 2% of income range from $1 to $20 per month. These amounts may be split between spouses, increased for tobacco surcharges, or reduced due to member rollover.

Table 4.1.1: HIP Plus Contribution Tiers

FPL	Monthly PAC Single Individual	Monthly PAC Spouses	PAC with Tobacco Surcharge	Spouse PAC when one has Tobacco Surcharge	Spouse PAC when both have Tobacco Surcharge (each)
<22%	$1.00	$1.00	$1.50	$1.00 & $1.50	$1.50
23-50%	$5.00	$2.50	$7.50	$2.50 & $3.75	$3.75
51-75%	$10.00	$5.00	$15.00	$5.00 & $7.50	$7.50
76-100%	$15.00	$7.50	$22.50	$7.50 & $11.25	$11.25
101-138%	$20.00	$10.00	$30.00	$10.00 & $15.00	$15.00

The State will determine the member's required monthly POWER Account contribution and will notify the Contractor of this amount. The Contractor will be responsible for applying any tobacco surcharge or rollover credits or discounts to the POWER Account contribution amount determined by the State. At the State's discretion, the State may give sixty (60) days' notice prior to requiring the Contractor to track members' tobacco use indicator and applying the surcharge to the POWER Account invoice. The POWER Account contribution will change only when a member has an FPL change that moves the member to a different tier. Members may prepay their POWER account contribution amounts and the Contractor is responsible for refunding any member overpayments.

13.1.2 HIP Basic Member Cost-Sharing

Members enrolled in HIP Basic or HIP State Plan Basic are not required to make

monthly contributions to their POWER Account, but are required to pay the following copayments at the time services are rendered:

- No copayment is required for preventative care, maternity services or family planning services.
- Four-dollar ($4.00) copayment is required for outpatient services.
- Seventy-five-dollar ($75.00) copayment is required for inpatient services.
- Four-dollar ($4.00) copayment is required for preferred drugs.
- Eight-dollar ($8.00) copayment is required for non-preferred drugs.

The Contractor shall also establish education and policies and procedures for its contracted providers to collect copayments for HIP Basic members at the time of service.

Any cost-sharing imposed on members must be in accordance with requirements at 42 CFR 447.50 through 42 CFR 447.57, 42 CFR 438.108, sections 1916(a)(2)(d) and 1916(b)(2)(D) of the Act.

13.1.3 HIP State Plan Member Cost-Sharing

Other than individuals exempt from cost-sharing as set forth in Section 13.1.4, all members receiving HIP State Plan benefits shall either pay POWER Account contributions in the amounts set forth in Section 13.1.1 if the member is enrolled in HIP State Plan Plus, or copayments for services as set forth in Section 13.1.2 if the member is enrolled in HIP State Plan Basic. Members that qualify as medically frail under Section 12.3.2 may be subject to both HIP Plus contributions and copayments when their income is over 100% of the FPL and they have not made their POWER account contributions.

13.1.4 Exempt Populations

Pursuant to federal law, the Contractor may not collect POWER Account contributions or impose any other cost-sharing, including co-payments for non-urgent use of hospital emergency departments, on members who are pregnant, or members identified as an American Indian/ Alaska Native (AI/AN) pursuant to 42 CFR 136.12, 42 CFR 447.52(h), 42 CFR 447.56(a)(1)(x), ARRA 5006(a), and 42 CFR 447.51(a)(2). The State will identify all AI/AN members through the eligibility determination process.

13.1.5 Tobacco Surcharge

HIP tobacco users who do not cease tobacco use will be charged a tobacco surcharge.

A tobacco user is defined as a person who uses tobacco on average of four (4) or more times per week with a look back period of six (6) months from the date of attestation. The definition of tobacco includes: chewing tobacco, cigarettes, cigars, pipes, hookah, and snuff. The determination to charge a surcharge is only accessed at the beginning of the benefit period and will apply for the entire benefit period. The tobacco surcharge is calculated as 50% of the member's POWER account contribution. The Contractor is responsible for calculating, tracking, and billing the tobacco surcharge on the member's monthly invoices. The Contractor is responsible for applying the tobacco surcharge on a calendar year benefit period for members who have indicated they were a tobacco user in the prior benefit period and have had at least 12 months to access quit resources but have not indicated

they have stopped smoking. When assessing the application of the surcharge, the Contractor is responsible for identifying any member who has a self-attested tobacco indicator of Yes with a date of 12 months plus 1 day from the month being invoiced. Operational requirements are outlined in the MCE policy and procedure manual. The surcharge is applicable for the entire calendar year, even if the member's tobacco use status changes to No during the calendar year. POWER Account amounts will be determined per normal procedure by the eligibility system. The Contractor will invoice the tobacco surcharge based on the tobacco indicator, regardless of the Contractor's information on tobacco use collected via claims data.

*Core*MMIS will store the tobacco use indicator and date and will pass the information to the Contractor. The Contractor is responsible for allowing the individual to report tobacco use or cessation of tobacco use at any time. Member self-reporting of tobacco use requires the updating of indicator by the Contractor. The tobacco use indicator may be updated by the Contractor via a supplemental file at any time. The indicator is only updated when an individual self-attests to tobacco use or tobacco non-use. The indicator cannot be updated via utilization or risk assessment data. A member can have their designation changed from yes to no for smoking during the year; however, the change in the indicator does not impact the member's current tobacco surcharge. Once updated via the supplemental file, the indicator is passed back to the Contractor on the 834.

The Contractor is responsible for allowing for member grievances and appeals relating to the tobacco surcharge as detailed in the MCE Policy and Procedures manual. A formal grievance or appeal decision may change the member's tobacco surcharge during the benefit period.

13.2 State POWER Account Contributions

The State will fund any gap between a member's required contribution and the $2,500 deductible. For members on HIP Basic or HIP State Plan Basic who make copayments instead of POWER Account contributions, the State will fund the entire POWER Account.

For purposes of illustration, if a HIP Plus member's annual income is 100% FPL and their contribution is $15 per month, after 12 months of enrollment the member will be responsible for $180 of the POWER Account. When the POWER account is reconciled the state will pay $2,320 to the Contractor and any State POWER account balance not spent on covered member services will be refunded.

The State will make an initial contribution of $1,300 to the POWER Account promptly after receiving notice from the Contractor that the member's first POWER Account contribution has been processed. State contributions shall be credited to a member's POWER Account immediately upon receipt by the Contractor from the State. At the conclusion of the member's calendar year benefit period, the Contractor and the State shall reconcile the POWER Account balance in accordance with Section 14.9.3, which shall include determining any amounts owed by the State to cover the difference between the sum of the members required monthly contributions and the initial $1,300 contribution. During reconciliation, the maximum additional State liability towards the POWER Account will be $1,200 based on member claims and contributions.

13.3 Third Party POWER Account Contributions

Third parties, including the member's employer, are permitted to contribute towards an individual's POWER account contribution up to one hundred percent (100%) of the member's required POWER Account contribution amount. Such third-party contributions

shall be credited to a member's POWER Account upon receipt. Any third-party contribution shall be used to offset the member's required contribution only, and not the State's contribution.

The Contractor shall keep record of all contributions made by third parties on behalf of members and make available to the State as outlined in the HIP MCE Reporting Manual.

13.4 Recalculations

A member shall report all changes to the State that may affect eligibility and POWER Account contributions, including changes in income or family size, such as a death, divorce, birth or a family member moving out of the household. The State will notify the Contractor if a member's POWER Account contribution changes as a result of the reported change. The Contractor shall begin billing the new POWER Account contribution in the billing cycle immediately following the change.

13.5 Billing and Collections

The Contractor shall develop and mail invoices for HIP members that include the following information:

- The name of the Contractor;
- First name, last name and address of payor;
- First names of members;
- Current monthly POWER Account contribution owed;
- Tobacco surcharge owed;
- POWER Account contribution past due;
- Overpayment shown as credit;
- Payor MID of the person responsible for payment;
- Consequences of not paying the POWER Account contribution;
- Notice to send payment in all accepted forms, such as check, money order, on-line payment, unlimited electronic check or debit card via telephone, payroll deduction, automatic draft withdrawal from a designated account, cash payments or automated clearinghouse (ACH), including instructions on how to perform the transaction;
- How to notify the Contractor of an address change;
- How to report any change in household or household income;
- How to notify the Contractor when individuals or families have billing questions or concerns;
- How to contact the enrollment broker if the individual desires to change MCEs for just cause;

- Legal statement regarding bankruptcy, if applicable; and
- Any additional information as directed by FSSA.

Regardless of whether the Contractor subcontracts the billing and collections function to another entity, invoices and any other related billing and collections materials shall be sent under the Contractor's name, not the name of the subcontractor.

The Contractor shall translate invoices into Spanish, as well as any other languages that are spoken by at least three percent (3%) of the general population in the Contractor's service area as determined by annual report from translation line requests or are requested by FSSA. Currently, the State notifies the Contractor of Spanish-speaking members only.

At a minimum, the invoice mailing shall include an invoice with a detachable payment coupon and a return envelope. The return envelope shall include pre-paid postage. Occasional one-page inserts may be required by FSSA to explain programmatic or billing changes. The Contractor shall provide members the option to sign-up and receive invoices via e-mail.

The Contractor shall bill for, and collect, POWER Account contributions and tobacco surcharge payments on a monthly basis. Partial monthly payments may be accepted by the Contractor; however, the member shall pay the monthly payment in full within sixty (60) days from the first day of the coverage month for which the POWER account contribution is owed or be subject to the non-payment penalties described in Section 13.7.

The Contractor shall actively encourage members to make their POWER Account contributions utilizing member education, outreach and reminders. Member education and outreach should be included in new member materials and coordinated with any contact the Contractor makes with new members for health screenings, risk assessments and PMP selections.

The Contractor shall notify members when the member fails to make a POWER Account contribution and tobacco surcharge payment by the due date. The Contractor shall provide at least two (2) written notices of the delinquent payment as a payment reminder, the first of which shall be sent on or before the seventh (7^{th}) calendar day of non-payment. The reminders shall include the following information, at a minimum:

- The date by which the contribution shall be paid to prevent the non-payment penalties described in Section 13.7.
- An explanation of the nonpayment penalty policies, including the exceptions as described in Section 13.7.1. The reminder shall also include information on how the member may request a medically frail screening in accordance with Section 12.3.2.2.
- For members over 100% FPL facing termination for non-payment, an explanation that any final notice of termination from the program will come directly from the State and will include information about the member's appeal rights.
- For members over 100% FPL not subject to an exception listed in Section 13.7.1, a reminder that if the member is terminated from HIP for non-payment, the member's portion of their POWER Account balance will be subject to a twenty-five percent (25%) penalty.

- An explanation of the member's appeal rights.
- Information regarding how to report any change in household composition or household income.
- A member helpline phone number for the member to call if they have any questions.

13.5.1 Payment Methods

The Contractor shall provide at least the following options for making payment:

- Check;
- Money order;
- Automatic payroll deduction;
- Cash;
- On-line payment via web portal;
- Unlimited electronic check or debit card payment via telephone;
- Automatic draft withdrawal from a designated account;
- Automated Clearinghouse (ACH); and
- Electronic funds transfer.

The cash payment process shall be available through a statewide network of banks or other entities in the business to handle/accept payments. In the case of a member with multiple employers, the Contractor is only required to provide the payroll deduction option for one of the member's employers at any given time. As an example, if the member changes employers, the member shall be permitted to make payments via payroll deduction with the new employer; however, if a person has multiple jobs, it is only required that the Contractor be able to accept one payment via payroll deduction at a time. Innovation by the Contractor in assuring the collection of member payments is highly desired.

Because POWER Account contributions are used to fund HIP members' $2,500 deductible, HIP conditionally eligible and fully eligible members shall be permitted to pre-pay some or all of their POWER Account contribution for the coverage period upon request at any time, including with their initial payment. Although additional payments may fully offset future billing, this does not relieve the Contractor's responsibility to send monthly invoices reflecting the amount due and credits on the account.

13.5.2 Employer and Other Third-Party POWER Account Contributions

The Contractor shall develop a program to publicize to members and employers that an employer and other third parties may contribute to the member's POWER Account.

Appropriate outreach materials should be developed and the Contractor shall assure that its member services staff can address calls from members, employers, and other third parties on this topic. Communications about employer contributions should be on-going and continuous, and the Contractor should consider collecting member employment data at the time of the health needs screening or other member contacts to use in its outreach efforts. The outreach materials for employers shall identify the process the employer can use to contribute to employee POWER Accounts.

Employers shall be allowed to make POWER Account contribution payments on a

monthly basis. If an employer fails to provide its share of a member's POWER Account contribution within sixty (60) calendar days of its due date, the member shall have an additional sixty (60) calendar days to pay the overdue amount before being terminated from HIP.

The Contractor shall also allow employers and other third parties to make lump sum POWER Account payments. The Contractor shall ensure that lump sum payments are credited against the member's required POWER Account contributions on a first month's basis. For example, for a member with a $10.00 per month contribution, if an employer or other third party makes a one-time $50.00 contribution, the Contractor shall immediately credit the member's account and apply the payment to cover the immediately following five months of required member contributions.

13.6 Enrollment and Initial POWER Account Contributions

13.6.1 Standard Enrollment

The standard initial billing and enrollment process described in this Section 13.6.1 shall be in effect for all applicants. The Contractor shall be required to comply with the fast-track initial billing and enrollment process described in Section 13.6.2 below for all fast-track eligible applicants identified by the State.

Except for American Indian/ Alaska Native (AI/AN) members, HIP member eligibility shall not be final until the first day of the month in which either (i) the POWER Account contribution is paid, or (ii) non-payment is determined for individuals at or below 100% FPL who choose not to participate in HIP Plus. A member's initial POWER Account contribution is due within sixty (60) calendar days of the date the Contractor receives a member's conditionally eligible file from the State.

The Contractor shall receive conditional eligibility files of individuals that selected, or were auto-assigned to, the Contractor's plan from the State. Within three (3) business days of receiving the conditional eligibility file, the Contractor shall send a Welcome Letter and initial invoice to the individual for their first POWER Account contribution. The first invoice shall reflect the member's monthly POWER Account contribution as determined by the State.

The Welcome Letter shall include a notice explaining that the individual shall submit their initial payment within sixty (60) calendar days in order to receive HIP Plus benefits. The notice shall be tailored to individuals at or below 100% FPL and those above 100% FPL. The Welcome Letter to individuals above 100% FPL shall explain that if the initial payment is not received within sixty (60) calendar days, the member's coverage will not commence and they will have to reapply for HIP. The Welcome Letter to individuals at or below 100% FPL shall explain that if the initial payment is not received within sixty (60) calendar days, their coverage under HIP Basic will begin on the first day of the month in which the sixty (60) day period ends. The Welcome Letter shall also have a notice prominently displayed on the first page stating in substance that the individual has the right to select another MCE before the first payment is made. Such notice shall include information for how the individual may contact the enrollment broker to change MCEs. As with all member communications, the Welcome Letter shall be reviewed and approved by the State prior to use in accordance with Section 4.1.

The Contractor shall provide at least two reminders to individuals who have not made their first monthly POWER Account contribution.

Except for AI/AN members, an individual's enrollment in the Contractor's plan begins the first day of the month in which the first POWER Account contribution is processed, or after the nonpayment determination has been made for individuals eligible for HIP Basic or HIP State Plan Basic. The Contractor shall process all payments and notify the State of the payment within fifteen (15) calendar days of receiving the payment. The fifteen (15) calendar day period allows time to assure that payments made by check have cleared.

Members identified as an AI/AN pursuant to 42 CFR 136.12 are exempt from all cost-sharing, as set forth in Section 13.1.4, and therefore such member's enrollment in the Contractor's HIP Plus plan begins the first day of the month in which the member applied to the plan.

13.6.2 Fast Track Enrollment

Except for AI/AN members, HIP eligibility shall not be final until either (i) the first day of the month in which the member pays an initial contribution to their POWER Account, or (ii) until the first day of the month in which the initial POWER Account fast track prepayment period expires for individuals at or below 100% FPL who choose not to participate in HIP Plus. For purposes of clarification, a member may enroll in HIP Plus by choosing to pay an initial ten dollar ($10.00) fast track POWER Account prepayment or the member's first month's POWER Account contribution in an amount determined by the State.

Fast track eligible applicants will be provided the opportunity to pay a ten dollar ($10.00) initial fast track POWER Account prepayment that expedites enrollment into the HIP Plus plan once an individual has been determined eligible by the State. The applicant may pay the fast-track prepayment either immediately at the time of application or following receipt of a fast-track invoice from the applicant's MCE.

For applicants that select an MCE and elect to pay via credit card at the time of application, the State will connect the applicant directly to the selected MCE's third-party payment partner to collect and process each applicant's credit card payment. The Contractor shall store the application ID number, payment amount, and payment date at least until the date the Contractor is notified by the State of the applicant's final eligibility determination. The Contractor shall receive pending eligibility files of individuals that selected, or were auto-assigned to, their plan from the State and meet fast track eligibility criteria. The Contractor shall review all pending eligibility files and identify applicants who have provided payment information to the Contractor via the Indiana Health Coverage Program application. If the Contractor successfully verifies the payment, the Contractor shall send the State notice of payment within one (1) business day of receiving the pending eligibility file.

Within two (2) business day of receiving the pending eligibility file of either (i) an applicant who did not pay the fast-track payment via credit card on the Indiana Health Coverage Application or (ii) whose credit card information was unable to be successfully verified and/or processed, the Contractor shall send an initial invoice to the individual for a ten-dollar ($10.00) POWER Account fast track prepayment. The invoice shall include a notice explaining that the individual has not yet been determined eligible for HIP benefits, but the initial fast track prepayment shall be paid within sixty (60) calendar days in order for the potential member to be eligible to receive HIP Plus benefits. The notice shall encourage prompt payment of the fast-track prepayment which could advance the potential member's benefit start date. Further, the initial invoice shall also include a prominent notice stating in substance that the potential member has the right to select another MCE at any time before the

first payment is made. Such notice shall include information for how the potential member may contact the enrollment broker to change MCEs.

In addition, the notice shall clearly indicate that the fast-track prepayment is an optional payment that either (i) will be fully refunded to the individual in the event the pending applicant is determined by the State not to be eligible for HIP, or (ii) will be applied towards the member's future required POWER Account contribution(s) in the event the potential member is determined eligible for HIP. The notice shall explain that if the member is determined eligible for HIP, their monthly POWER account contributions may be greater than the initial fast track prepayment, in which case, the member may owe more in the second month in order to continue to receive HIP Plus benefits. As with all member communications, the fast-track enrollment notice shall be reviewed and approved by the State prior to use in accordance with Section 4.1.

A member's fast track prepayment or initial POWER Account contribution is due within sixty (60) calendar days of the date the Contractor receives the member's pending eligibility file from the State. The Contractor shall provide at least two (2) reminders during the sixty (60) day payment period to individuals who have not made their initial fast track prepayment or first monthly POWER Account contribution. The Contractor shall process all payments and notify the State of the payment within fifteen (15) calendar days of receiving the payment. The fifteen (15) calendar day period allows time to assure that payments made by check have cleared. Notwithstanding the foregoing, the Contractor may elect to hold fast track prepayments received from applicants not yet determined eligible by the State until such time the applicant is determined eligible. If the Contractor elects to hold such payments, the Contractor shall verify the payment and notify the State of receipt of a valid payment method within fifteen (15) calendar days of receipt. Once the applicant is determined eligible, the Contractor shall release the hold and process payment no later than fifteen (15) calendar days from the Contractor's receipt of the eligibility file. A member's enrollment in the Contractor's plan begins as follows:

i. If the member pays either the fast-track prepayment or the initial POWER Account contribution within the original sixty (60) day fast track payment period, the effective date of coverage is the first day of the month in which the member made his or her initial payment. Potential members who pay the fast-track prepayment prior to the State's eligibility determination will be directly opened into HIP Plus benefits upon the State's final eligibility determination.

ii. Members who have an open presumptive eligibility segment and make a fast-track payment with their full IHCP application will open into HIP Plus the first day of the month following their fast-track payment.

iii. If the potential member does not pay the fast-track prepayment or their initial POWER Account contribution within the sixty (60) day payment period but is found otherwise eligible for HIP, the potential member will become conditionally eligible for HIP following the eligibility determination, and either:

    a. the effective date of coverage will be the first day of the month in which the sixty (60) day fast track prepayment period expired for individuals below 100% FPL or who are otherwise exempt from non-payment penalties in accordance with Section 13.7.1; or

    b. the individual will be determined ineligible and will have to reapply

for HIP benefits if the individual is over 100% FPL and is not otherwise exempt from non-payment penalties in accordance with Section 13.7.1.

iv. Members identified as an AI/AN pursuant to 42 CFR 136.12 are exempt from all cost-sharing, as set forth in Section 13.1.4, and therefore, unless such member opts of out managed care via the process determined by the State, such member's enrollment in the Contractor's HIP Plus or HIP State Plan Plus plan, as applicable, begins the first day of the month in which the individual applied for the plan.

As described in subsection (ii) above, a potential member who is determined eligible for HIP by the State before the initial fast track prepayment was received and prior to the expiration of the sixty (60) day fast track payment period, will be considered conditionally eligible. Within three (3) business days of receiving the conditionally eligible file, the Contractor shall send a Welcome Letter to the conditionally eligible member. The Welcome Letter shall be tailored to individuals at or below 100% FPL and those above 100% FPL.

a) The Welcome Letter to members above 100% FPL shall explain that if either the initial fast track prepayment or full POWER Account contribution is not received prior to the expiration of the sixty (60) day fast track payment period, the member's coverage will not commence and they will have to reapply for HIP.

b) The Welcome Letter to members at or below 100% FPL shall explain that if either the initial fast track prepayment or full POWER Account contribution is not received prior to the expiration of the sixty (60) day fast track payment period, the member's coverage under HIP Basic will begin on the first day of the month in which the payment period expires.

The Contractor's Welcome Letter to all conditionally eligible members who have not yet made a fast track prepayment shall include a notice that if the member's POWER Account contribution is greater than ten dollars ($10.00) the initial fast track prepayment is the minimum required to obtain HIP Plus benefits and start the program, however, the member will remain responsible for the full amount of the POWER Account contribution during the first month of coverage and such amount will be included on the subsequent month POWER Account invoice. The Welcome Letter shall also have a notice prominently displayed on the first page stating in substance that the individual has the right to select another MCE at any time before the first payment is made. Such notice shall include information for how the individual may contact the enrollment broker to change MCEs. As with all member communications, the Welcome Letter shall be reviewed and approved by the State prior to use in accordance with Section 4.1.

Due to the fact that the Contractor may collect the initial fast track prepayment before the member's individual POWER Account contribution has been determined by the State, the Contractor will be required to reconcile any overpayments or underpayments resulting from the fast-track prepayment. Specifically, if the member's POWER Account contribution is less than the fast-track prepayment, the Contractor shall credit the fast-track prepayment against the member's required POWER Account contributions on a first month's basis. For example, for a member with a $1.00 per month contribution, the Contractor shall immediately credit the member's account and apply the payment to cover the first ten months of required member contributions. By contrast, if the member's POWER Account contribution is greater

than the fast-track prepayment, the Contractor shall credit the fast-track prepayment to the member's first month's required POWER Account contribution and add the remaining balance to the member's subsequent POWER Account contribution. The member will have sixty (60) calendar days to pay the remaining balance.

For individuals who pay their fast-track prepayment within the sixty (60) day payment period but who are determined ineligible for HIP, the Contractor shall return any such funds within ten (10) business days of the determination.

13.7 Non-Payment of Monthly POWER Account Contribution

Other than the exceptions listed in Section 13.7.1, HIP members who do not make a required POWER Account contribution within sixty (60) calendar days of its due date or an initial fast track prepayment prior to the expiration of the sixty (60) calendar day fast track period will either be (i) terminated from the program and disenrolled from the Contractor's plan if the member has income greater than 100% FPL, or (ii) transferred to HIP Basic benefits if the member has income equal to or less than 100% FPL or are otherwise exempt from non-payment penalties, in accordance with Section 13.7.1. Notwithstanding the foregoing, upon non-payment, members receiving HIP State Plan benefits who either have income equal to or less than 100% FPL or are otherwise exempt from non-payment penalties as set forth in Section 13.7.1 will be required to make co-payments consistent with Section 13.1.2, but will not be subject to a change in benefits.

Payment via a dishonored check due to non-sufficient funds (NSF) will be considered non-payment, and members who have made such a payment will be terminated from the program or transferred to HIP Basic, as applicable, if they are unable to provide the full amount that is in delinquency within sixty (60) calendar days of its original due date. If a member's check is returned for non-sufficient funds, the Contractor may charge a reasonable fee for the returned check. The Contractor shall develop, print and mail notices to members if their payments are returned from the bank due to non-sufficient funds.

The Contractor shall notify the State, through *Core*MMIS, when a member does not pay their initial fast track prepayment by its due date, or their POWER Account contribution within sixty (60) calendar days of its due date. Upon the expiration of the payment due date, if no payment has been received, the Contractor shall send notification to the State electronically in accordance with the HIP MCE Policies and Procedure manual no later than three (3) business days from the expiration of the payment due date. The Contractor shall wait until either a termination record is received from the State to terminate a fully enrolled member from the plan, or until other notice is received from the State indicating a change in benefits to HIP Basic.

13.7.1 Non-Payment Penalty Exceptions

Members exempt from cost-sharing pursuant to Section 13.1.4 shall not be subject to any of the non-payment penalties set forth in Section 13.7. In addition, certain members will be exempt from program disenrollment due to non-payment as set forth in Section 13.7.2. The Contractor is responsible for informing members of these non-payment penalty exceptions as detailed in Sections 13.7 and 4.4. Refer to the HIP MCE Policies and Procedures Manual for specific information related to the non-payment penalty exceptions.

13.7.2 Disenrollment Exceptions

The following members will not be subject to disenrollment due to non-payment:

Members confirmed medically frail in accordance with Section 12.3.2 will not be terminated from the program due to non-payment. In the event a medically frail member with income over 100% FPL does not make a payment within sixty (60) calendar days of its due date, the Contractor shall notify the State of nonpayment as detailed in Section 13.7. However, the medically frail member will continue to receive HIP State Plan benefits, but will be required to make copayments consistent with Section 13.1.2. The Contractor shall continue to send monthly POWER Account invoices to such medically frail members above 100% FPL, and the member will continue to incur debt to the Contractor for unpaid POWER Account contributions. The Contractor shall ensure that the member's total expenses, including any paid debt, copayments, and POWER account contributions, do not exceed the five percent (5%) of income maximum during any quarter as set forth in Section 3.16. Members may regain access to HIP State Plan Plus without copayments during their 12-month eligibility redetermination in accordance with Section 14.6.

i. Parent/caretaker members receiving transitional medical assistance (TMA) as set forth in Section 12.3.1 shall either attain or remain in HIP Plus coverage for up to twelve (12) months during their TMA eligibility period as long as POWER Account contributions are made. If after the first six (6) months of TMA coverage income remains over 138% but below 185% FPL, coverage can extend an additional six (6) months as long as POWER Account contributions are paid.

14.0 Personal Wellness & Responsibility (POWER) Accounts

The Contractor shall establish and administer a POWER Account for each HIP member, regardless of whether the member is required to contribute to the POWER Account. HIP members will use the funds in their POWER Account to meet their $2,500 deductible. POWER Accounts are administered on a calendar year basis, and a member who leaves HIP and returns within the same calendar year will have their POWER account reactivated.

As explained in Section 13.0 above, HIP members, the State and, in some cases, employers and other third parties will contribute to the POWER Account. POWER Accounts are designed to provide incentives for members to stay healthy, be value- and cost-conscious and to utilize services in a cost-efficient manner as well as to seek price and quality transparency. HIP members shall be aware that prudent management of their health care expenditures can leave them with available POWER Account funds at the end of the calendar year benefit period—and that these funds can be used to lower next year's contribution for participation in HIP Plus.

The POWER Account requirements set forth in this section apply only to the Contractor's HIP members. The Contractor shall be required to comply with the requirements set forth in these documents as of the effective date of the Contract.

14.1 POWER Account Administration

POWER Accounts will be funded in an amount equal to $2,500. HIP Plus members, as well as the State, will contribute to their POWER Account. Employers are also encouraged to contribute to member POWER Accounts. By contract, HIP Basic members will manage a POWER Account fully funded by the State. HIP Maternity members will have a POWER Account, however, this account will be in suspended status and no claims may be applied to it for the duration of the member's HIP Maternity enrollment.

In families with two or more HIP-eligible adults, each member will have their own, individual POWER Account. Family members may participate in different HIP benefit plans and may choose to enroll in different MCEs.

14.2 Use of POWER Account Funds

Each member will be responsible for the use of funds in his or her POWER Account until the deductible is met. However, POWER Account funds can only be used by the member to pay for HIP covered services applicable to the member's HIP benefit plan. A summary list of the HIP covered services by benefit plan is provided in Exhibit 3.B of this Contract. Any service not specifically listed as a covered benefit in the applicable HIP alternative benefit plan may not be applied against the POWER Account.

In spending POWER Account funds, members shall be permitted to pay for the following covered services, even if obtained through out-of-network providers:

- Family planning services, if obtained from a IHCP provider;
- Emergency medical services;
- Other self-referral services outlined in Section 3.2, if obtained from a IHCP provider;
- Medically necessary covered services, if the Contractor's network is unable to provide the service within a 60-mile radius of the member's residence, as specified in 42 CFR 438.206(b)(4), which addresses out-of-network coverage of necessary services, and Section 3.14; and
- Nurse practitioner services, if provided by an IHCP provider.

Members shall not use POWER Account funds to pay for the emergency room services co-payment described in Section 3.6.2 or HIP Basic co-payments described in Section 13.1.2.

14.3 Provider Reimbursement and the POWER Account

Participating providers shall be reimbursed at a rate not less than the minimum fee schedule established by the State when a member purchases covered services with POWER Account funds. When sufficient funds exist in the member's POWER account, the entire payment is deducted from the POWER account.

However, if there are insufficient funds in the member's POWER Account, the Contractor must cover the service in full. In these cases, the Contractor can recover any funds it pre-pays on the member's behalf with future POWER Account contributions paid by the member.

14.3.1 Directed Payment for Eligible Out-of-State Children's Hospitals

In accordance with IC 12-15-15-1.2, Indiana Medicaid will reimburse inpatient hospital and outpatient hospital services provided to HIP members less than 19 years of age by eligible out-of-state children's hospitals at one hundred thirty percent (130%) of the Medicaid reimbursement rate. Per 42 CFR § 440.20, outpatient hospital services mean preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

(1) are furnished to outpatients;

(2) are furnished by or under the direction of a physician or dentist; and

(3) are furnished by an institution that:

(i) is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

(ii) meets the requirements for participation in Medicare as a hospital; and

(4) may be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State.

14.4 POWER Account Balance Information

The Contractor shall maintain up-to-date member POWER Account balance information. This information shall be mailed to members on a monthly basis in the form of a POWER Account Statement. The POWER Account Statement shall be available online via a secure member portal. The information shall reflect real-time changes in the member's POWER Account, as evidenced by paid claims. It shall also indicate the member's annual and monthly contribution amounts and the State's estimated annual contribution amount.

POWER Account balance information shall also be available to members by contacting the Contractor's Member Helpline.

The Contractor shall give members an opportunity to elect to receive e-mail alerts about updated POWER Account balance information on the member's secure member portal, in addition to or as an alternative to receiving the information by mail.

In providing the required POWER Account balance information, the Contractor may combine the information with the Explanation of Benefit (EOB) information required in Section 4.4.5.

14.5 Interest

Neither members nor the Contractor may retain interest on POWER Accounts. The Contractor shall keep POWER Account funds in a safe, interest bearing account that accrues a minimum interest annually of 1% or the Effective Federal Funds Rate (EFFR) as of July 1st of the year, whichever is smaller. Contractor shall report quarterly on the type of account, balance, and interest rate of accrual to the State. This account should be separate from other funds. On an annual basis at the end of each calendar year, the Contractor shall report in the aggregate the interest accrued on its members' POWER Accounts. The Contractor shall return this amount to the State within sixty (60) calendar days after the end of each calendar year. Interest mechanisms may not prohibit prompt payment of claims.

14.6 Audit Requirement

The Contractor shall engage an external entity to conduct an annual audit of its POWER Account operations and administration.

14.7 Member 12 Month Eligibility Period

Members must have their eligibility redetermined by the State every 12 months. Member eligibility redetermination occurs 12 months from the member's HIP start date. The Contractor will receive the member's eligibility redetermination date from the State. The Contractor is responsible for reaching out to members prior to their redetermination to encourage them to complete required redetermination paperwork.

In the first month of the member's new eligibility period, HIP Basic members will receive a Potential Plus determination as outlined in Section 12.2.1. The assignment of Potential Plus will provide members with the opportunity to move from HIP Basic to HIP Plus by making their POWER Account contribution or fast track payment.

If a member is determined to remain eligible for HIP at the end of an eligibility period, the member's POWER Account contribution will need to be verified. The State will update the member's POWER Account contribution as necessary based on any changes in the member's income recognized during redetermination. POWER Accounts follow the calendar year benefit period (January through December) and do not mirror the eligibility period.

14.8 Rollover

At the end of a calendar year benefit period, members shall have the opportunity to rollover funds from the current calendar year's POWER account to the next calendar year's POWER account. For members that continue enrollment in HIP, any member contributed funds remaining in the member's POWER Account may be used to offset the member's required POWER Account contribution in the subsequent calendar year benefit period. The amount rolled over or discounted shall depend on whether the member was in HIP Plus or HIP Basic at the end of the previous calendar year, and if the member received his or her recommended preventive care services. To allow a claims run-out period, the rollover/ discount calculation shall occur no later than one hundred and twenty-one (121) calendar days following the end of the calendar year benefit period.

In performing the POWER Account rollover function, the Contractor shall comply with the procedures set forth in this section, as well as all additional policies and procedures included in the HIP MCE Policies and Procedures Manual and IC 12-15-44.5-4.9. The Contractor shall be required to comply with the requirements set forth in these documents as of the effective date of the Contract. The Contractor shall have the capability to transmit the required rollover data electronically as of the effective date of the Contract. This capability will be tested during the readiness review.

14.8.1 Recalculation of Member Contributions

The State fiscal agent will notify the Contractor of the member's POWER Account contribution for the new benefit period. After the 12-month calendar year reconciliation period, the Contractor shall report any applicable POWER Account rollover amounts determined in accordance with Section 14.8.2.1 or any discounts determined in accordance with Section 14.8.2.2 to the State fiscal agent on the POWER Account Reconciliation file (PRF), as set forth in Sections 14.8.2 and 14.8.3 below. The Contractor shall notify members of any rollover amounts, as well as any changes in their monthly POWER Account contribution due to rollover amounts or discounts applied. If a HIP Basic or HIP State Plan Basic member is eligible for a discount for participation in HIP Plus, the Contractor shall notify the member of the opportunity to transfer to HIP Plus benefits or HIP State Plan Plus at the discounted rate.

Due to the fact that the first POWER Account installment in the new calendar year benefit period may become due before the member's individual contribution has been recalculated by the State, the member may be billed by the Contractor according to the required contribution schedule. However, the Contractor will be required to reconcile any overpayments or underpayments made by the member after being notified by the State of the member's rollover amount or discount for the new benefit period.

14.8.2 POWER Account Rollover

Where a member has funds remaining at the end of the calendar year benefit period, some of the funds remaining in the member's POWER Account may be rolled over into the next calendar year benefit period for purposes of reducing the member's required HIP Plus or HIP State Plan Plus POWER Account contributions. Only member rollover dollars can be applied to the tobacco surcharge. Rollover is applied to the member's new account 121 days following the end of the calendar year benefit period.

The amount of leftover funds available for rollover will depend on the member's contributions to the POWER Account, the balance remaining in the member's POWER Account, any member debt, and the member's receipt of recommended preventive care services. For each benefit period, FSSA will determine, based on Centers for Disease Control recommendations, which recommended preventive care services apply to a specific member's age and gender, as well as the member's pre-existing conditions.

POWER Accounts are designed to encourage preventive care, the appropriate utilization of health care services and personal responsibility. The Contractor shall develop multiple methods of emphasizing to members that responsible use of POWER Account funds, as well as obtaining recommended preventive care services, can lead to a reduced financial burden in the next benefit period. If members are aware that prudent management of their health care expenditures can leave them with available funds at the end of the calendar year benefit period—and that these funds can be used to lower their contribution requirements for the following benefit period— members will be encouraged to make value- and cost-conscious decisions. See Section 4.4.4 for required POWER Account member education responsibilities.

The Contractor may collect any member debt from the member portion of rollover funds determined in accordance with the rollover calculations detailed below. Under no circumstances shall State rollover funds be used to pay member debt. In collecting member debt from rollover funds, the Contractor shall comply with the specific calculations established in the HIP MCE Policies and Procedures Manual.

14.8.2.1 HIP-Plus Rollover

HIP Plus members and HIP State Plan Plus members who consistently contribute to their POWER account during the calendar year benefit period will be eligible to rollover the member's unused pro rata share of the POWER Account balance.

If a HIP Plus member or HIP State Plan Plus member receives any recommended preventive care service during the calendar year benefit period, the member will be eligible to have their unused share, or "rollover amount", doubled by the State as an added incentive. Depending on the balance in the POWER Account, this rollover amount may significantly reduce or even eliminate the member's required contributions in future benefit periods.

Any remaining State funds shall be credited back to the State.

The rollover amounts for HIP Plus members and HIP State Plan Plus members are calculated as follows:

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1. First, the member's portion of the remaining POWER Account balance (the Member Share) is determined by the following formula:

   Divide the sum of member incurred month POWER account contributions *by* 2,500 (the fully funded POWER account total).

2. Second, the Base Rollover Amount is determined as follows:

   Member Share (from #1) *multiplied by* the claims paid from the POWER account. This is the member's claims responsibility for the year. Any payments made by the member in excess of their claims responsibility can be rolled over to the next calendar year.

   Subtract this from the sum of required monthly contributions paid by the member.

   Where the result is positive this is the member's Base Rollover Amount. Where the result is negative the member has debt.

3. Finally, the Final Rollover Amount is determined based on whether the member obtained recommended preventive services and if the member has a tobacco surcharge. The preventive services bonus is applied to the Base Rollover Amount as follows to determine the Final Rollover Amount:

   For members without a tobacco surcharge:

   If preventive services are completed during the plan year:

   Base Rollover Amount x 2 = Final Rollover Amount

   If preventive services are not completed during the plan year:

   Base Rollover Amount x 1 = Final Rollover Amount

   For members with a tobacco surcharge:

   For members with a tobacco surcharge, only member rollover dollars may be applied to the surcharge amount; State rollover dollars may not be applied. Members that earn a rollover discount have the discount applied to the original PAC, not to the surcharged PAC. The tobacco surcharge is applied to the original PAC, not the surcharged PAC, and then the results are summed for the member's final PAC. When calculating the State rollover amount on a tobacco surcharge member, a member will earn 2/3 of the member contributions remaining.

Consider the following example:

A member who contributes $120.00 over 12 months of enrollment ($10 per month) to the POWER Account over the course of a benefit period and the State contributes $2,380 for a combined contribution of $2,500 ($120 + $2,380 = $2,500). Under the scenario, the member's pro rata share of the total POWER Account is .048 (120/2500).

The member spends $2,100 of POWER Account funds to pay for covered services during the benefit period. At the end of the benefit period, $400 remains in the member's POWER Account (2,500 - $2,100 = $400).

If the member did not obtain any of the preventive care services recommended by FSSA for the member's age, gender and pre-existing conditions before the end of the benefit period, only the member's pro rata share of the remaining POWER Account balance will be rolled over. In this case, the member's pro rata share would be $19.20 (the member's share as determined above- .048 x $400). This $19.20 will be available to be rolled over and applied to the member's required POWER Account contributions in the subsequent benefit period. The $19.20 is rolled over to the subsequent account functions as a credit towards the member's current POWER account contribution responsibility.

If the member did not have a tobacco surcharge and obtained any of the preventive care services recommended by FSSA for the member's age, gender and pre-existing conditions before the end of the benefit period, the rollover amount calculated in the previous example would be doubled. The base rollover amount of $19.20 would be multiplied by a factor of 2, or a total rollover amount of $36.04 is rolled over to the subsequent account functions as a credit towards the member's current POWER account contribution responsibility.

If the member had a tobacco surcharge and obtained any of the preventive care services recommended by FSSA for the member's age, gender, and pre-existing conditions before the end of the benefit period the State match equates to 2/3 of the member dollars remaining ($24.02). There is no State match on tobacco surcharge.

Since rollover occurs one-hundred and twenty-one (121) days after the start of the subsequent benefit period, the rollover amount in both scenarios above would be applied as a credit on the member's account. If the rollover amount calculated is in excess of the member's required POWER Account contribution for the next benefit period, the excess amount will be credited as specified in the HIP MCE Policy and Procedure Manual. Prior year rollover does not roll over to the next year, and any remaining rollover from the prior year must be refunded.

14.8.2.2 HIP Basic Rollover

HIP Basic members and HIP State Plan Basic members who did not contribute to their POWER accounts will not have the ability to "rollover" funds, since they did not participate in funding the POWER account. However, HIP Basic members and HIP State Plan Basic members will still maintain the incentive to manage the POWER account judiciously and receive recommended preventive care services, as such members may be eligible for a HIP Plus discount directly related to the percentage of the POWER Account balance remaining at the end of the plan year. For example, if a member has 40% of their POWER account balance remaining at the end of the benefit year, the member may reduce their required HIP Plus contribution by 40% in the following year, provided the member has received their recommended preventive services. However, in no event may a member receive greater than a fifty percent (50%) discount in the subsequent benefit year. Discount Percentage cannot be applied to $1.00

PAC requirements, regardless of if a discount is received on the 834.

The rollover amounts for members participating in the either HIP Basic or HIP State Plan Basic are calculated as follows:

1. First, the Rollover Percentage is calculated by the following formula: Remaining balance in the POWER account

   Divided by 2,500 (the fully funded POWER account total)

   Multiplied by 100 to yield a percentage < = 50%

2. The determination of the Final Discounted Contribution amount for participation in the HIP Plus plan for the subsequent year would be determined as follows:

   Required contribution for the subsequent year based on FPL

   Minus [Rollover Percentage *multiplied by* the required contribution]

Consider the following example:

A member on HIP Basic, does not contribute to the POWER Account. However, through actively managing the account, the member only spends $2100 of the POWER Account funds to pay for covered services during the benefit period. At the end of the benefit period, $400 remains in the member's POWER Account ($2500 - $2100 = $400).

If the member did not obtain any of the preventive care services recommended by FSSA for the member's age, gender and pre-existing conditions before the end of the benefit period, the member would not be eligible for any HIP Plus discount in the subsequent year. The member would be offered the opportunity to transfer to HIP Plus one time at eligibility redetermination with a $10.00 per month contribution requirement. The Contractor shall credit the full remaining POWER balance of $400 to the State.

If the member obtained any of the preventive care services recommended by FSSA for the member's age, gender and pre-existing conditions before the end of the benefit period, the rollover would be calculated by dividing the remaining balance in the account ($400) by the full amount of the account ($2,500). This amount is then multiplied by one hundred (100) to yield a percentage, which in this scenario is 16%. This discount is then applied to the contribution required for the member's HIP Plus participation. If the member's contribution amount to transfer to HIP Plus was $10.00 per month, the 16% discount would reduce the required monthly contribution to $8.40. The State will fund the discount provided to member's who receive a discount and are enrolled in HIP Plus coverage.

In accordance with Section 14.8.1, the Contractor shall notify the State fiscal agent of the applicable member rollover discount. Where applicable the state will provide the member the opportunity to move to HIP Plus benefits. The Contractor shall notify the member of the available discount, and provide the member the opportunity to begin making POWER Account

contributions and transfer to HIP Plus benefits, or to HIP State Plan Plus cost- sharing, as applicable. Prior year rollover does not roll over to the next year, and any remaining rollover from the prior year must be refunded.

14.8.3 Recommended Preventive Care Services

Annually, FSSA will determine which recommended preventive services qualify a member for rollover or discount. The Contractor shall send preventive service reminders to their members throughout the benefit period, including in the monthly POWER Account Statements and redetermination correspondence.

The Contractor shall have mechanisms in place to monitor when a member has obtained the preventive care services recommended for his or her age and gender, as well as pre-existing conditions, and report this information on the PRF one hundred and twenty-one (121) calendar days following the end of the member's benefit period.

The Contractor shall monitor whether a member has received recommended preventive care services by:

1. Utilizing claims data to determine if any of the certain specified disease conditions exist;

2. Utilizing claims data to determine if required services have been obtained (FSSA shall provide the qualifying CPT and/or ICD-10 codes, as applicable); and

3. If, after #1 and #2, preventive services cannot be verified, the Contractor may require the member to submit verification of preventive services.

Members will only be required to complete disease-specific preventive services if they were diagnosed with the disease prior to the beginning of the benefit period. If a disease develops mid-benefit period, the member will not be required to complete preventive care services related to that disease until the next benefit period.

Ninety (90) calendar days prior to the end of a member's benefit period, the Contractor shall make an initial assessment (through claims and other information, as described above) of whether the member has completed the recommended preventive services. If the member has not received recommended preventive services, the Contractor shall send a reminder to the member. The reminder shall notify the member that the Contractor's records indicate that the member **has not** received recommended preventive services based on medical claims received as of a specified date. A general listing that outlines what was required for different ages, genders and disease types is sufficient, it does not need to be specific to the member. The reminder shall also explain the appropriate rollover incentive based on the member's benefit plan that the member would be eligible to receive in the subsequent benefit period following completion of any recommended preventive service. This correspondence should be coordinated with other redetermination reminders and shall be provided no later than sixty (60) calendar days prior to the end of the member's benefit period.

Sixty (60) calendar days after the end of a member's benefit period, the Contractor shall make an assessment (through claims and other information, as described above) of whether the member has completed the recommended preventive services. The Contractor shall send a letter to the member informing the member of

its assessment if the assessment indicates that the member has not received the recommended preventive care. This letter shall go out within the sixty (60) calendar day period.

1. The letter to the member does not need to spell out what services the member received and what were not received. The letter shall only indicate that the required preventive care services were not completed.

2. The letter to the member shall list what the required preventive care services were for the member's benefit period. A general listing that outlines what was required for different ages, genders and disease types is sufficient, it does not need to be specific to the member.

3. The Contractor shall develop a form that can be easily completed by a member's physician which verifies that the member's age and sex appropriate services have been obtained. This form shall be included in the letter to the member.

4. If the Contractor's records indicated that the member has not received the recommended preventive services, the Contractor shall allow the member to file a grievance on the decision by submitting documentation that indicates that they did in fact receive the required preventive care. The form included in the member's letter can be used as supporting documentation, but shall be completed by the member's physician.

5. The letter shall indicate that the member has sixty (60) calendar days from receipt of the letter to file a grievance on the decision and submit additional information using the attached form. The Contractor may incorporate this grievance process into its existing grievance and appeals process, but shall ensure that the grievance is resolved in a time period that allows for timely submission of a complete and accurate PRF to the State.

6. If a member changes MCEs during their annual open enrollment period, the Contractor (e.g., original MCE) is responsible for resolving any grievances related to preventative care services.

Example language that should be included in the letter to the member includes:

i. The required preventive service(s) for the year was "X".

   - *For HIP Plus members*: Because you regularly contributed to your POWER Account throughout the year, you are eligible to rollover your unused share of the remaining POWER Account balance. If you also received the required preventive services, your "rollover amount" will be doubled by the State in order to further reduce the cost of the plan in the next benefit period.

   - *For HIP Basic members*: If you received your required preventive services, you will be eligible to receive a discount on the required monthly POWER account contributions if you would choose to participate in HIP Plus in the next year. The discount will be based on a percentage of your remaining POWER Account balance at the end of your current benefit period.

ii. A preliminary review of our records indicates that you have not received the

required preventive service(s).

iii. If you believe our preliminary determination is in error and you have received the preventive services listed above, please fill out the attached form and submit it to "X". The form shall be filled out by your physician and returned within thirty (30) calendar days.

Further detail regarding preventive service monitoring and reporting is set forth in the HIP MCE Policies and Procedures Manual.

14.8.4 POWER Account Reconciliation

POWER Accounts align to the calendar year. The member's POWER Account covers the first $2,500 of eligible services in each calendar year. Members that continue enrollment in HIP for multiple calendar years have a POWER account assigned to them for every calendar year in which they are enrolled. Where a member leaves HIP and then reenters the program within the same calendar year, the member's POWER account is reactivated. To allow for claims runout, one hundred and twenty-one (121) days following the end of the calendar year, the POWER account is reconciled with the state. The Contractor shall submit an initial reconciliation for the member rollover thirty (30) days after the end of their benefit period.

During the one hundred and twenty-one (121) calendar day reconciliation period, the Contractor shall notify the State of whether the member obtained the recommended preventive services and the amount, if any, of either the member's POWER Account that will be rolled over to reduce the next benefit period's required contribution or the percent discount that will be applied to reduce the member's participation in HIP Plus. This notice shall also indicate the amount, if any, of the member's POWER Account that will be credited back to the State and other data as required by the State. This information shall be provided on the PRF, which is an electronic transaction between the Contractor and the State fiscal agent. See POWER Account technical requirements and the HIP MCE Policies and Procedure Manual.

The Contractor shall be required to comply with these requirements as of the effective date of the Contract.

Member rollover amounts and the State's refunds shall be reported even if the amount is zero, in order to verify to the State that the reconciliation process is finalized. Any amounts reported as owed to the State will be transferred to the State via the 820 transaction. The Contractor may not make adjustments after the PRF is filed one hundred and twenty-one (121) calendar days following the end of the member's benefit period. Any PRF transactions filed with errors must complete the void and replace process.

The Contractor shall be required to comply with these requirements as of the effective date of the Contract. Reconciliation must be demonstrated at readiness review.

14.9 Termination of Eligibility

If a member becomes ineligible for HIP, either during eligibility redetermination or at another time, the Contractor shall inactivate the member POWER Account. To allow for members that return to the program, the account will be held inactive through the end of the calendar year. Per IC 12-15-44.5-4.9, one hundred and twenty (120) days following the end of the calendar year, the Contractor will refund the State and member share of the

remaining POWER Account balance, if any. This section is also applicable when an American Indian/ Alaska Native member elects to opt-out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for-service benefits through the State.

Any prepaid balance in excess of member's pro rata share of the remaining POWER Account balance, as determined in accordance with Section 14.9.1, shall be refunded to the member immediately, if requested by the member. Otherwise, any remaining overpayments will be refunded no later than one hundred and twenty (120) days after the end of the calendar year benefit period. The State share shall be reported one hundred and twenty-one (121) calendar days following the end of the calendar year.

In performing the POWER Account reconciliation function when a member loses eligibility, the Contractor shall comply with the procedures set forth in this section and HIP MCE Policies and Procedures Manual. POWER Account technical requirements are updated from time to time. The Contractor shall be required to comply with these requirements as of their effective date. The Contractor shall have the capability to transmit the required reconciliation data electronically as of the effective date of the Contract. This capability will be tested during the readiness review.

14.9.1 Terminated Member Refund

If a member becomes ineligible for HIP or otherwise disenrolls from HIP, either during redetermination or at another time, the Contractor shall refund the member's pro rata share of his or her POWER Account balance, immediately, if requested by the member. Otherwise, any remaining overpayments will be refunded **within one hundred and twenty (120) calendar days** after the end of the calendar year benefit period (IC 12-15-44.5-4.9). If the Contractor sends a POWER Account refund check to a member and the check is returned to the Contractor because the member cannot be located, the Contractor shall handle the member's unclaimed refund pursuant to Indiana Statute (IC 32-34-1.5, et seq.).

A deceased member's estate will have a right to the member's pro rata share of his or her POWER Account funds.

Except for members terminating from the program who are subject to non-payment penalties for such termination as described below, the amount payable to the member shall be determined as follows:

- Step One: Determine the amount of POWER account contributions owed by the individual for the months of enrollment in HIP Plus or HIP State Plan Plus.
- Step Two: Divide the amount determined in Step One by 2500.
- Step Three: Multiply the ratio determined in Step Two by the total amount spent from the POWER Account.
- Step Four: Subtract the amount determined in Step Three from the member paid to Contractor for months enrolled in HIP Plus. Where the result is positive the member is owed a refund of that amount. Where the result is negative the member may owe a debt and is not due a refund.

A member who does not otherwise meet any of the exceptions listed in Section 13.7.1 will be subject to a penalty on the member's refund amount if such member is either terminated from HIP due to non-payment or voluntarily withdraws from HIP prior to the end of the member's benefit period. Such member will forfeit to the State twenty-five

percent (25%) of his or her pro rata share of any funds remaining in the member's POWER Account. This means that upon member termination from HIP due to non-payment, the Contractor shall be required to refund only a portion of the member's pro rata share of the POWER Account. In certain instances, the State may waive the application of the penalty. Where there is a penalty assessed, the amount payable to the member shall be determined as follows:

- Step One: Where the amount determined in Step Four of the previous section is positive, multiply this amount by 0.75.
- Step Two: Refund the member the amount calculated in Step One. Refund the State the amount of the member penalty.

14.9.2 Member Refunds Due to Members with Continuous Coverage

PRF are completed at 121 days following the end of the calendar year benefit period. At the time of the PRF reconciliation funds due to members will be determined. If funds rolled over to the next benefit period result in an overpayment The MCE must refund any member's overpayment due to rollover or any other remaining member funds. The refund must be provided within 150 calendar days of the benefit period end. (This will allow for claims run out and initial PRF calculation.)

The amount payable to the member shall be determined as follows:

- Step One: Determine the amount of POWER account contributions owed by the individual for the months of enrollment in HIP Plus or HIP State Plan Plus.
- Step Two: Divide the amount determined in Step One by 2500.
- Step Three: Multiply the ratio determined in Step Two by the total amount spent from the POWER Account.
- Step Four: Subtract the amount determined in Step Three from the member paid to Contractor for months enrolled in HIP Plus. Where the result is positive the member is owed a refund of that amount. Where the result is negative the member may owe a debt and is not due a refund.

14.9.3 State Refund

Any funds remaining in the POWER Account after the member rebate shall be credited to the State via the 820 transaction. The Contractor will have one hundred and twenty-one (121) calendar days from the end of the calendar year to report the amount to the State.

14.9.4 POWER Account Reconciliation

In the event of member termination, the POWER Account reconciliation process occurs as below:

- Terminated Member refund: If a member becomes ineligible for HIP or otherwise disenrolls from HIP, then the MCE must refund any POWER Account contribution (PAC) overpayments to the member immediately, if requested by the member. Otherwise, any remaining overpayments will be

refunded no later than one hundred and twenty (120) days after the end of the calendar year benefit period.

- Members with continuous coverage refund: The MCE must refund any member's overpayment due to rollover or any other remaining member funds. The refund must be provided within 150 calendar days of the benefit period end. (This will allow for claims run out and initial PRF calculation.)

- State refund: One-hundred and twenty-one (121) calendar days from end of the calendar year

One hundred and twenty-one (121) calendar days following the end of the calendar year, the Contractor shall notify the State fiscal agent of the amount of the member and state refunds and other data set forth in the PRF File Layout. This information shall be provided on the Power Account Reconciliation File (PRF), which is an electronic transaction between the Contractor and the State fiscal agent.

Member and state refunds shall be reported even if the amount is zero, in order to verify to the State that the reconciliation process is finalized. Any amounts reported as owed to the State will be transferred to the State via the 820 transaction.

Once the final PRF is filed one hundred and twenty-one (121) calendar days following the end of the calendar year, the Contractor may only make adjustments via the void process at the approval of the State. The Contractor shall be responsible for any claims received after the POWER Account has been reconciled and/or member refund has been issued. All missing POWER Account payment and capitation must be reported to the Indiana Medicaid fiscal agent and FSSA and reconciled no later than two years following the end of the benefit period. The Contractor shall not pursue the member's portion of an appealed claim after a member refund is made.

The Contractor shall be required to comply with these requirements as of the effective date of the Contract. FSSA will provide a timeline prior to reconciliation start date so that adjustments to the required submission timeframes can be made as needed. Reconciliation must be demonstrated at readiness review.

The Contractor must refund any member overpayments within 120 calendar days of the end of the member's benefit period. The refund of overpayments and the rollover of previous year's rollover balances occurs regardless of whether the member obtained his or her recommended preventive care services. Because a member cannot receive a rollover credit for the first five months in a following benefit period, until reconciliation, they can receive a refund for an overpayment that was made in the first five months before receiving their rollover credit or discount. Refunds for overpayments are issued during the POWER Account reconciliation process. Members that terminate may be refunded prior year member rollover dollars. At the end of benefit period applied if there are remaining member rollover dollars, those will be refunded to the member as a current year overpayment.

14.10 POWER Account Debt Collection Process

Members may incur debt to the MCEs through missed POWER account payments. Notwithstanding the foregoing, member debt may not exceed the following amounts:

1. An amount that does not exceed the quarterly cost share maximum; or

2. An amount that does not exceed the sum of the unpaid required monthly contributions during months in which the member received HIP Plus coverage but was not contributing to the POWER Account.

The Contractor may register and collect any debt owed by the member to the Contractor. The Contractor shall register the debt with the State fiscal agent. The State fiscal agent will document the debt owed and the MCE to whom the debt is owed. If the Contractor pursues the member debt, the Contractor shall do so in accordance with standard company practice for collection of debt in the individual market segment. However, the Contractor shall not (i) sell the member's debt, (ii) report the debt to credit reporting agencies, (iii) place a lien on the member's home, (iv) refer the case to debt collectors, (v) file a lawsuit, or (vi) seek a court order to seize a portion of the member's earnings. The Contractor may collect member debt from member rollover dollars. Any member debt collected by the Contractor shall be included in the member's quarterly five percent (5%) cost sharing maximum described in Section 3.16.

The Contractor shall comply with the debt collection policies and procedures set forth in HIP MCE Policies and Procedures Manual. The Contractor shall be required to comply with the requirements set forth in the document as of the effective date of the Contract.

14.11 POWER Account Balance Transfers

If a member terms from an MCE and moves to another MCE during the calendar year benefit period, the PRF termination process is utilized.

By day one hundred and twenty-one (121) days after the end of the HIP calendar year benefit period, the final term (FT) PRF is submitted by the MCE to the State fiscal agent.

MCEs refund the member as defined above within one hundred and twenty (120) days or one hundred and fifty (150) days after the calendar year benefit period ends if PRF indicates that the member overpaid or did not have claims to apply against the entire balance of their contributions. The Contractor shall comply with the MCE transfer policies and procedures set forth in the HIP MCE Policies and Procedures Manual as well as the POWER Account technical requirements. The Contractor shall be required to comply with the requirements set forth in the documents as of the effective date of the Contract.

14.12 POWER Account Systems

The Contractor shall have an IT that is capable of automating the required POWER Account transactions, including the 820, 834 and PRF transactions, in compliance with the data specifications set forth in the State fiscal agent's Companion Guides. The Contractor shall provide real-time access to member POWER Account balances in a secure format.

The Contractor shall have policies, procedures and mechanisms in place to support the POWER Account requirements set forth in the HIP MCE Policies and Procedures Manual and the State fiscal agent's Companion Guides, as may be amended from time to time. The Contractor shall have policies, procedures and mechanisms in place to support accuracy, security and privacy in the Contractor's administration of member POWER Accounts. The contractor shall conform to state and federal requirements for ensuring member financial and

debit card information is secure.

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EXHIBIT 2B

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Except as defined below or where the context requires otherwise, all capitalized terms shall have the meanings ascribed to them in the Contract.

Note that previous versions of this Exhibit that relate specifically to previous years (calendar years 2023 and 2024) exist. The specific final requirements for each of these specified years, will regulate the requirements and calculations applied to each of these previous periods, unless changes specifically addressing previous years are made.

EXHIBIT 2B

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES – CALENDAR YEAR 2025

A. Contract Compliance

1. Non-compliance Remedies

It is the State's primary goal to ensure that the Contractor and its subcontractors/vendors deliver quality care to members while maintaining the program integrity of the State of Indiana's HIP program. To assess attainment of this goal, the State monitors certain quality and performance standards, and holds the Contractor accountable for being in compliance with Contract terms. FSSA accomplishes this by working collaboratively with the Contractor to maintain and improve programs, and not to impair Contractor stability.

In the event that the Contractor and/or its subcontractors/vendors fails to meet performance requirements or reporting standards set forth in the Contract or other standards established by the State, the State will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies discussed below or in this Contract. The State will provide written notice of non-compliance to the Contractor within sixty (60) calendar days of the State's discovery of such non-compliance. The State will provide the Contractor with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains the basis and nature of the sanction, and will include any appeal rights the State elects to provide, in accordance with 42 CFR 438.710(a)(1)-(2).

If FSSA elects not to exercise a corrective action clause contained anywhere in the Contract in a particular instance, this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the Contract, may be retroactively assessed.

2. Corrective Actions

In accordance with 42 CFR 438, Subpart I, FSSA may require corrective action(s) when the Contractor has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The written notice of non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, any of the following:

- Written Warning: FSSA may issue a written warning and solicit a response regarding the Contractor's corrective action.

- Formal Corrective Action Plan: FSSA may require the Contractor to develop a formal corrective action plan to remedy the breach. The corrective action plan must be submitted under the signature of the Contractor's chief executive and must be approved by FSSA. If the corrective action plan is not acceptable, FSSA may provide suggestions and direction to bring the Contractor into compliance.

- Withholding Full or Partial Capitation Payments: FSSA may suspend capitation payments for the following month or subsequent months when the State determines that the Contractor is materially non-compliant. FSSA must give the Contractor written notice ten (10) business days prior to the suspension of capitation payments and specific reasons for non-compliance that result in suspension of payments. The State may continue to suspend all capitation payments until CMS or the State are satisfied that non-compliance issues are corrected and not likely to reoccur.

EXHIBIT 2B

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

- Suspending Auto-assignment: FSSA may suspend auto-assignment of members to the Contractor. The State may suspend all auto-assignment or may selectively suspend auto-assignment for a region or county. The State will notify the Contractor in writing of its intent to suspend auto-assignment at least ten (10) business days prior to the first day of the suspension period. The suspension period may be for any length of time specified by the State. The State will base the duration of the suspension upon the nature and severity of the default and the Contractor's ability to cure the default.

- Granting Members the Right to Disenroll Without Cause: The State may permit members the right to disenroll from the Contractor without cause.

- Suspending All New Enrollments: The State may suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

- Assigning the Contractor's Membership and Responsibilities to Another Contractor: The State may assign the Contractor's membership and responsibilities to one (1) or more other Contractors that also provide services to the Healthy Indiana Plan population, subject to consent by the Contractor that would gain that responsibility. The State must notify the Contractor in writing of its intent to transfer members and responsibility for those members to another Contractor at least ten (10) business days prior to transferring any members. This option also includes permitting members the right to disenroll from the Contractor without cause.

- Appointing Temporary Management of the Contractor's Plan: The State may assume management of the Contractor's plan or may assign temporary management of the Contractor's plan to the State's agent, in accordance with 42 CFR 438.706(a) and Section 1932 (e)(2)(B)(1) of the Social Security Act. Temporary management may be imposed if at any time the State determines that there is continued egregious behavior by the Contractor, there is substantial risk to enrollees' health; or the sanction is necessary to ensure the health of the Contractor's enrollees in one of two circumstances: while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the Contractor. Temporary management will be imposed when the Contractor repeatedly fails to meet substantive requirements in section 1903(m) or 1932 of the Social Security Act or 42 CFR 438. The State may not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines that the Contractor can ensure the sanctioned behavior will not reoccur per 42 CFR 438.702 and Section 1932 (e)(2)(B)(ii) of the Social Security Act. If the State imposes temporary management because the Contractor has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438, the State will notify affected enrollees of their right to terminate enrollment without cause in accordance with 42 CFR 438.706(b).

- Contract Termination: The State reserves the right to terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any term or condition of this Contract, or failure to take corrective action as required by FSSA to comply with the terms of this Contract. The State must provide thirty (30) calendar days written notice and must set forth the grounds for termination.

The State may impose additional sanctions provided for under State statutes or regulations to address noncompliance per 42 CFR 438.702(b).

EXHIBIT 2B

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

3. Liquidated Damages

In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Contract, or other standards set forth by the State, it is agreed that damages shall be sustained by the State, and the Contractor shall pay to the State its actual or liquidated pursuant to this Contract, its actual damages, and/or penalties as expressly permitted under 42 USC Chapter Seven, Subchapter XIX, Section 1396u-2 (e).

It is agreed that in the event of a failure to meet specified performance or reporting requirements subject to liquidated damages, it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the State will sustain in the event of, and by reason of, such failure; and it is therefore agreed that the Contractor will pay the State for such failures according to the following subsections. No punitive intention is inherent in the following liquidated damages provisions.

FSSA may impose remedies resulting from failure of the Contractor to provide the requested services depending on the nature, severity, and duration of the deficiency. In most cases, liquidated damages will be assessed based on this Exhibit. Should FSSA choose not to assess damages for an initial infraction or deficiency, it reserves the right to require corrective action or assess damages at any point in the future.

The State shall notify Contractor of liquidated damages due and Contractor shall pay the State the full amount of liquidated damages due within ten (10) business days of receipt of the State's notice. The State may, in its sole discretion, elect at any time to offset any amount of liquidated damages due against capitation payments otherwise due Contractor pursuant to the Contract.

In the event liquidated damages are imposed under the Contract, the Contractor must provide FSSA with a formal corrective action plan, as well as monthly reports on the relevant performance metrics until such time as the deficiency is corrected for a period determined by the State.

4. Non-compliance with Reporting Requirements

The MCE Reporting Manual, distributed following the Contract award and periodically thereafter, details the required formats, templates and submission instructions for the reports listed in the Contract. FSSA may change the frequency of required reports, or may require additional reports, at FSSA's discretion. The Contractor will be given at least thirty (30) calendar days' notice of any change to reporting requirements.

If the Contractor's non-compliance with the reporting requirements impacts the State's ability to monitor the Contractor's solvency, and the Contractor's financial position requires the State to transfer members to another Contractor, the State will require the Contractor to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement Contractor as a result of member transfer. In addition the Contractor must pay any costs the State incurs to accomplish the transfer of members. Further, FSSA will withhold all capitation payments or require corrective action until the Contractor provides satisfactory financial data.

5. Performance and Reporting Requirements

Minimum recommended sample sizes for Hybrid and Survey measures must be met. Any report which requires a minimum sample size (e.g., CAHPS, HEDIS) will be rejected if they do not meet the established minimum standards for sampling. If Contractor fails to submit any report by the required deadline or fails to utilize the required sample sizes, the Contractor may forfeit eligibility for participation in the pay for outcomes program as described in Section B of this Exhibit and the Contractor will be subject to corrective actions as set forth in Section A.2 of this Exhibit.

EXHIBIT 2B

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

If Contractor fails to submit any report in the MCE Reporting Manual in a timely, complete and accurate manner (other than the HEDIS and CAHPS reports), Contractor shall pay liquidated damages of five thousand and two hundred dollars ($5,200) for each month each report (other than the HEDIS or CAHPS reports) is not submitted in a timely, complete, or accurate manner.

If Contractor fails to submit a HEDIS or CAHPS report that was based on the National Committee for Quality Assurance (NCQA) methodology for sampling data, Contractor shall pay liquidated damages of five thousand and two hundred dollars ($5,200) for each month each report is not submitted in a timely, complete, or accurate manner.

Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate reports required under the Contract.

6. Encounter Data Quality Report

FSSA recognizes the importance of monitoring Contractor performance throughout the calendar year, and Contractor shall be required to submit quarterly Encounter Data Quality reports to FSSA in a timely, complete and accurate manner, for the HIP program in accordance with the Reporting Manual. Each quarterly report must include year-to-date information and must be verified to a degree of at least ninety-eight percent (98%) completeness for all claims (i.e., an incompleteness rate of no more than 2.0%). The Healthy Indiana Plan Reporting Manual details the requirements for submission of Encounter Data Quality reports.

FSSA will use Contractor's encounter data, or other method of data completion verification deemed reasonable by FSSA, to verify the completeness of the Encounter Data Quality report in comparison to Contractor's encounter claims. FSSA reserves the right to change the method of data completion verification upon reasonable advance notice to the Contractor.

To the extent Encounter Data Quality submissions or underlying encounter data is used in a public report, it must be received by stated deadline in order to be published.

If, during any quarter after the first year of the Contract, Contractor fails to submit Encounter Data Quality reports to FSSA in a timely, complete and accurate manner, and does not meet the ninety-eight percent (98%) completeness threshold, the Contractor shall pay liquidated damages of forty-nine thousand and two hundred dollars ($49,200), per quarter.

Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate Encounter Data Quality reports required under the Contract.

7. Non-compliance with Shadow/Encounter Claims Submission Requirements

Payment of liquidated damages as outlined below does not relieve Contractor of its responsibility to provide complete and accurate shadow/encounter claims required under the Contract.

a. Weekly Batch Submission

The Contractor must submit at least one (1) batch of encounter data for paid and denied institutional, professional, and pharmacy claims in a standardized secure format, as specified by FSSA on a weekly basis. If, during any calendar month, Contractor fails to submit all encounter claims on a weekly basis when due, unless delay is caused by technical difficulties of FSSA or its designee, Contractor will pay liquidated damages in the amount of four thousand, eight hundred fifty dollars ($4,850) for each claim type for which shadow/encounter claims were not submitted in a timely manner.

b. Pre-cycle Edits

For each weekly encounter claims batch submission, Contractor must achieve no less than a ninety-seven percent (97%) compliance rate with pre-cycle edits. The State will assess pre-cycle edit compliance based upon the average compliance rate of the weekly encounter claims batch submissions made during the calendar month and will calculate compliance separately for institutional, professional and pharmacy claims. If the average compliance rate is below ninety-seven percent (97%), Contractor shall pay liquidated damages in the amount of five thousand, four hundred and sixty dollars ($5,460) for each deficient shadow claim type. Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate shadow claims required under the Contract.

c. Prescription Drug Rebate File

Contractor shall comply with the required layouts for submitting pharmacy claim extracts used to support federal drug rebate invoicing and collection. The frequency of file submissions and the content of the files supporting drug rebate invoicing and collection are defined by FSSA and pertain to all pharmacy claim transactions and medical claim transactions that contain physician administered drugs as set forth in The Scope of Work. Contractor shall provide this reporting to FSSA in the manner and timeframe prescribed by FSSA, including, but not limited to, through a rebate file to the State or its designee. For any instance in which the Contractor fails to provide required files for drug rebate purposes in a timely, accurate, or complete manner, the Contractor shall be responsible for interest, based on the interest calculation for late rebate payments methodology published by CMS, on delayed rebate money owed to the State. For example, if the Contractor fails to meet the FSSA established deadline for submission of the claim extracts and/or rebate file and the drug rebate contractor completes the quarterly drug rebate invoicing process without the Contractor's claim information for the invoicing quarter, the Contractor shall reimburse the State for interest on the rebate amount later calculated by the drug rebate contractor, for the period of delay in collecting the rebate amount. Such reimbursement shall be due within thirty (30) days of presentation of the interest calculation.

d. SUPDL Compliance Report.

The Contractor shall make all appropriate efforts to meet SUPDL adherence expectations for the Contract Year as set and if directed by FSSA, including but not limited to targets for specific classes. FSSA shall provide the Contractor with such SUPDL adherence targets at least annually. Such adherence targets may change during the Contract Year.

FSSA shall calculate, for SUPDL adherence targets, at least quarterly, whether the Contractor is on track to meet adherence targets for the Contract Year and provide the Contractor with a report showing the results.

FSSA annually shall calculate whether the Contractor met SUPDL adherence targets for the Contract Year and provide the Contractor with a report showing the results.

For SUPDL adherence calculations, FSSA shall use Encounter Data to determine the ratio of claims for Preferred products paid by the Contractor compared to claims for all products paid by the Contractor. The SUPDL calculation may be done at the therapeutic class level and be normalized for day supply.

If Contractor fails to meet SUPDL adherence targets, FSSA may assess a penalty equal to the number of prescriptions outside the target range times the average differential in rebate between a preferred product and a non-preferred product.

EXHIBIT 2B

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

8. Network Access

If FSSA determines that the Contractor has not met the network access standards established in the Contract, FSSA shall require submission of a Corrective Action Plan to FSSA within ten (10) business days following imposition of sanctions. Determination of failure to meet network access standards shall be made following a review of the Contractor's Network Geographic Access Assessment Report. The frequency of required report submission shall be outlined in the Healthy Indiana Plan MCE Reporting Manual. Contractor will pay liquidated damages in the amount of five thousand, two hundred and fifty dollars ($5,250) for each reporting period that the Contractor fails to meet the network access standards. Upon discovery of noncompliance, the Contractor shall be required to submit monthly Network Geographic Access Assessment Reports until compliance is demonstrated for sixty (60) consecutive days. FSSA may also require the Contractor to maintain an open network for the provider type for which the Contractor's network is non-compliant. Further, should Contractor be out of compliance for three (3) consecutive months as a result of failure to meet network access standards, FSSA shall immediately suspend auto-enrollment of members with the Contractor, until such time as Contractor successfully demonstrates compliance with the network access standards.

9. Marketing Violations

Per 42 CFR 438.704(b)(1), if the Contractor distributes marketing materials that have not been approved by the State or that contain false or misleading information, either directly or indirectly through any agent or independent contractor the State may impose a civil monetary penalty of up to $25,000 for each such distribution.

10. Member and Provider Communication and Education Violations

Per 42 CFR 438.704(b)(1), if the Contractor misrepresents or falsifies information that it furnishes to a member, potential enrollee, or health care provider, the State may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation. In addition, FSSA reserves the right to require an immediate retraction or correction by the Contractor, in a format acceptable to FSSA. For illustration purposes only, a violation will be determined to exist if Contractor promulgated or distributed, directly or indirectly through any agent or independent contractor, member and or provider communication or education material that have not been approved by FSSA or those that have been approved by FSSA that Contractor identifies as containing inaccurate, false or misleading information. For further illustration, a violation will be determined to exist if the Contractor distributes any member or provider communication, including member or provider letters, bulletins, alerts, press releases or other press communications, bulletins and forms, without prior approval by FSSA. For purposes of this Section, provider communications are limited to provider communications related to the HIP programs.

11. Claims Payment

If Contractor fails to pay or deny ninety-eight percent (98%) or more of any type of clean claims within the required timeframe, Contractor shall pay liquidated damages in the amount of five thousand, seven hundred dollars ($5,700) for each deficient claims type. For the purposes of this section, there are six claims types: professional paper claims, professional electronic claims, facility paper claims, facility electronic claims, pharmacy paper claims, and pharmacy electronic claims. This section includes payment of dental claims.

12. Provider Claim Disputes

Contractor must resolve and respond to ninety-nine percent (99%) of provider informal claim disputes within thirty (30) calendar days of receipt of the dispute. The Contractor must resolve and respond to ninety-nine percent (99%) of provider formal disputes within forty-five (45)

calendar days of the receipt of the dispute. For each quarter in which Contractor fails to provide and communicate a timely resolution on ninety-nine percent (99%) of informal and/or formal disputes, Contractor shall pay liquidated damages in the amount of two thousand, three hundred and ten dollars ($2,310).

13. Readiness Review

If Contractor fails to satisfactorily pass the readiness review at least thirty (30) calendar days prior to scheduled member enrollment (or other deadline as may be established at the sole discretion of the State), the State may delay member enrollment and/or may require other remedies (including, but not limited to Contract termination), and Contractor shall be responsible for all costs incurred by the State as a result of such delay.

In addition, for each business day that Contractor fails to submit readiness review responses beyond their expected due date, Contractor shall pay liquidated damages in the amount of five thousand, four hundred, and fifty dollars ($5,450). Damages will be assessed each time the requirement is not met. In each instance that Contractor shall pay liquidated damages in the amount of three thousand, fifty dollars ($3,050).

14. Member/Provider Helpline and Website Services

There are twelve (12) separate measures that will equally apply to the Healthy Indiana Plan Member/Provider Helpline and Website Metrics and the Pharmacy Helpline and Website Metrics Reports. For each instance in which the Contractor has failed to meet a metric for a given quarter, the Contractor shall pay liquidated damages in the amount of one thousand, four hundred and seventy dollars ($1,470) per quarter of non-compliance for each metric.

Helpline and Website Metrics: The twelve (12) metrics are:

i. For any calendar month, at least ninety-seven percent (97%) of all phone calls to the Helpline must reach the call center menu within thirty (30) seconds or the prevailing benchmark established by the NCQA.

ii. For any calendar month, at least eighty-five percent (85%) of all phone calls to an approved automated Helpline must be answered by a Helpline representative within thirty (30) seconds after the call has been routed through the call center menu. Answered means that the call is picked up by a qualified Helpline staff person.

iii. For any calendar month, at least ninety-five percent (95%) of all phone calls to an approved automated Helpline must be answered by a Helpline representative within sixty (60) seconds after the call has been routed through the call center menu. Answered means that the call is picked up by a qualified Helpline staff person.

iv. If Contractor does not maintain an approved automated call distribution system then, for any calendar month, at least ninety-five percent (95%) of all phone calls to the Helpline must be answered within thirty (30) seconds.

v. For any calendar month, the busy rate associated with the Helpline shall not exceed zero percent (0%).

vi. Hold time shall not exceed one (1) minute in any instance, or thirty (30) seconds, on average.

vii. For any calendar month, the lost call (abandonment) rate associated with the Helpline shall not exceed five percent (5%).

viii. Contractor must maintain an answering machine, voice mail system, or answering service to receive calls to the Helpline that take place after regular business hours. For any calendar month, one hundred percent (100%) of all after hours calls received must be returned or attempted to be returned within one (1) business day.

ix. Contractor must maintain a system to receive and address electronic inquiries via e-mail and through the member website. For any calendar month, one hundred percent (100%) of all electronic inquiries received must be responded to within one (1) business day.

x. Contractor's Helpline at all times must be properly equipped to accept calls including, without limitation, calls from members with limited English proficiency and calls from members who are deaf, hearing impaired or have other special needs.

xi. For any calendar month, eighty-five percent (85%) of all calls to the Helpline must be resolved during the initial call.

xii. Contractor must make pertinent information available to members and providers through an Internet website in an FSSA-approved format in accordance with the terms of the Contract. The website must be available for access by members no less than twenty-three and one-half (23.5) hours per day, on average.

15. Prior Authorization

Contractor must respond to requests for authorization of services in the format and within the timeframes set forth in the Contract. For each quarter in which the Contractor fails to adjudicate ninety-eight per cent (98%) or more of prior authorization requests within the required timeframes, Contractor shall pay liquidated damages in the amount of six thousand, six hundred and fifteen dollars ($6,615).

16. Member Grievances

Contractor must resolve one hundred percent (100%) of member grievances within thirty (30) calendar days of receipt of the grievance. For each quarter in which in which Contractor fails to provide and communicate a timely resolution on one hundred (100%) of member grievances, Contractor shall pay liquidated damages in the amount of three thousand, one hundred and fifty dollars ($3,150).

17. Member Appeals

Contractor must resolve one hundred percent (100%) of member appeals within thirty (30) calendar days of receipt of the appeal. For each quarter in which in which Contractor fails to provide and communicate a timely resolution on one hundred percent (100%) of member appeals, Contractor shall pay liquidated damages in the amount of two thousand, three hundred and ten dollars ($2,310). The Contractor must also provide a timely and satisfactory response to documentation required to facilitate member appeals in accordance with the FSSA Fair Hearing process. In addition, the Contractor shall provide a representative to participate in the FSSA fair hearing process to represent the State. For each instance in which the Contractor fails to either (i) provide a timely response to documentation required for the member appeal within the time frames set forth by FSSA, or (ii) upon adequate notice, represent the State at the FSSA fair

hearing, Contractor shall pay liquidated damages in the amount of one thousand, one hundred dollars ($1,100).

18. Provider Credentialing

Contractor shall process all credentialing applications within thirty (30) calendar days of receipt of a complete application. If FSSA determines that the Contractor has not processed all credentialing applications in a timely manner, FSSA shall require submission of a formal Corrective Action Plan within ten (10) business days following notification by the State. Upon discovery of noncompliance, Contractor shall be required to submit monthly provider credentialing reports until compliance is demonstrated for sixty (60) consecutive days.

19. Complaints and Internet Quorum Inquiries

The Contractor must resolve complaints and Internet Quorum (IQ) inquiries to FSSA's satisfaction, within the timeframes set forth by FSSA. Unless an alternative deadline is identified by FSSA for a specific IQ inquiry, IQ inquiries must be resolved in no more than five (5) business days. The Contractor may request additional time to respond, but FSSA is under no obligation to grant extensions. For each instance in which the Contractor fails to provide a timely or accurate response to complaints or IQ inquiries within the timeframes set forth by FSSA, Contractor shall pay liquidated damages in the amount of four hundred dollars ($400).

20. POWER Account Performance

Contractor must provide POWER Account services within the timeframes specified below. For each instance in which Contractor fails to meet the requirements of this section, Contractor shall pay liquidated damages in the amount of one thousand, six hundred and fifty dollars ($1,650).

a. Funds deposited by the State must be credited to a member's account within two (2) calendar days.

b. Member contributions via direct deposit or payroll withholding must be credited to the member's account within two (2) calendar days of deposit.

c. Member contributions via mailed paper check must be credited to the member's account within five (5) calendar days after the check has cleared. Member contributions via money order must be credited to the member's account within five (5) calendar days of payment receipt.

d. In the event that a member becomes ineligible for HIP or otherwise disenrolls from HIP, then the Contractor must refund any POWER Account contribution (PAC) overpayments to the member immediately, if requested by the member. Otherwise, any remaining overpayments will be refunded no later than one hundred and fifty (150) days after the end of the calendar year benefit period.

e. In the event that a member loses eligibility, the Contractor shall refund the State the balance of their POWER account within one hundred twenty-one (121) calendar days of the date the member loses eligibility.

f. POWER Account Reconciliation Files (PRFs) must be submitted in a timely and accurate manner for all members (including those with zero contributions), based upon the timeframes specified by the State.

EXHIBIT 2B

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

21. Medically Frail Identification

The Contractor shall be subject to an audit of Healthy Indiana Plan members designated as medically frail. The State will audit a minimum of five percent (5%) of all its members identified by the Contractor as medically frail. If the results of the audit indicate that inappropriate identifications have been made in greater than ten percent (10%) of the audited cases the Contractor shall pay liquidated damages as follows:

- If the State's auditor finds that inappropriate referrals have been made in greater than ten percent (10%) and less than or equal to twenty percent (20%) of audited cases, the Contractor shall pay liquidated damages in the amount of one percent (1%) of the total medically frail capitation (including administrative portion) received during the audit period.

- If the State's auditor finds that inappropriate referrals have been made in greater than twenty percent (20%) or more of audited cases, the Contractor shall pay liquidated damages in the amount of two percent (2%) of the total medically frail capitation (including administrative portion) received during the audit period.

Prior to imposing sanctions, Contractor, at its sole expense, shall have the right to dispute the State's auditor findings. Contractor may present to FSSA documentation used to determine member met the criteria for medically frailty. Sanctions will not be imposed if member met the medically frail criteria at the time of the referral. Information after the date of referral cannot be grounds for imposing sanctions.

The Contractor shall refund the State the difference between the applicable capitation rate and the capitation rate actually received as a result of the inappropriate medically frail designation.

22. Plan Solvency

If Contractor fails to meet solvency performance standards set forth below and as may be amended by the State, Contractor shall be subject to corrective actions as set forth in the Contract, including but not limited to Contract termination.

a. On a quarterly basis, current ratio (assets to liability) shall be greater than or equal to one (1).

b. On a quarterly basis, the number of day's cash on hand shall not be fewer than sixty (60) business days. Contractors may not count POWER Account balances as cash on hand. FSSA reserves the right to adjust the required number of days of cash on hand based on historical Contractor performance and the ability of the Contractor to demonstrate solvency.

c. On a quarterly basis, days in unpaid claims shall not be greater than sixty-five (65) business days.

d. On a quarterly basis, days in claims receivables shall not be greater than thirty (30) business days.

e. On a quarterly basis, equity (net worth) shall be maintained at or above $150 per member.

23. Non-compliance with General Contract Provisions

The objective of this requirement is to provide the State with an administrative procedure to address issues where the Contractor is not compliant with the Contract. Through routine

monitoring, the State may identify Contract non-compliance issues. If this occurs, the State will notify the Contractor in writing of the nature of the non-performance issue and the State may enforce any of the remedies listed in this Exhibit.

The State may enforce any of the remedies listed if the Contractor fails to perform any contractual requirement including, but not limited to, the following:

- Fails substantially to provide medically necessary services that the Plan is required to provide, under law or under its Contract with the State, to a member (note that per 42 CFR 438.704(b)(1), the State may impose a civil monetary penalty of up to $25,000 for each failure to provide services, as well as enforcing any of the remedies listed in Section A.2 above);

- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Healthy Indiana Plan Program (note that per 42 CFR 438.704(c), the State may impose a civil monetary penalty of up to $25,000 or double the amount of the excess charges (whichever is greater), as well as enforcing any of the remedies listed in Section A.2 above);

- Acts to discriminate among members on the basis of their health status or need for health care services, such as unlawful termination or refusal to re-enroll a member or engaging in any practice that would reasonably be expected to discourage enrollment by a potential enrollee whose medical condition or history indicates probable need for substantial future medical services (note that per 42 CFR 438.704(b)(2) and (3), the State may impose a civil monetary penalty of up to $100,000 for each determination of discrimination, the State may impose liquidated damages of up to $15,000 for each individual the Contractor did not enroll because of a discriminatory practice, up to the $100,000 maximum, and/or enforce any of the remedies listed in Section A.2 above);

- Misrepresents or falsifies information that it furnishes to CMS or to the State (note that per 42 CFR 438.704(b)(2), the State may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation, as well as enforcing any of the remedies listed in Section A.2 above);

- Misrepresents or falsifies information that it furnishes to a member, potential enrollee, or health care provider (note that per 42 CFR 438.704(b)(1), the State may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation, as well as enforcing any of the remedies listed in Section A.2 above);

- Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210 (note that per 42 CFR 438.704(b)(1), the State may impose a civil monetary penalty of up to $25,000 for each failure to comply, as well as enforcing any of the remedies listed in Section A.2 above); or

- Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

24. Other Non-Performance

If Contractor fails to meet the other performance standards set forth in the Contract, Contractor shall be subject to corrective actions or other remedies as set forth in this Exhibit.

EXHIBIT 2B

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

25. Restoring Operations Following a Disaster

Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within twenty-four (24) hours of identification of a disaster. If the Contractor's failure to restore operations requires the State to transfer members to another Contractor, to assign operational responsibilities to another Contractor or the State is required to assume the operational responsibilities, the State will require the Contractor to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement Contractor. In addition, the Contractor must pay any costs the State incurs associated with the Contractor's failure to restore operations following a disaster, including but not limited to costs to accomplish the transfer of members or reassignment of operational duties.

26. Advanced Notice of System Upgrades and Replacements

Contractor shall notify FSSA at least thirty (30) calendar days prior to the installation or implementation of minor software and hardware changes, upgrades, modifications or replacements and at least ninety (90) calendar days prior to the installation or implementation of major software or hardware changes, upgrades, modifications or replacements as defined in Section 8 of the Scope of Work. Contractor will be subject to corrective actions as set forth in Section A.2 of this Exhibit for failure to provide advanced notice in the required timeframe and may be required to delay implementation of the planned upgrade, modification or replacement.

27. Health Insurance Portability and Accountability Act (HIPAA) and Security Breaches

Contractor shall notify FSSA within one (1) business day upon discovery of a HIPAA, 42 CFR Part 2, or other security breach. Contractor shall be subject to corrective actions as set forth in Section A.2 of this Exhibit for failure to provide advanced notice in the required timeframe and must pay any costs the State incurs as a result of the violation.

28. Notification of System Outages

Contractor shall notify FSSA, at minimum, within two (2) hours of discovery of a disaster or other disruptions in its normal business operations. Contractor will be subject to corrective actions as set forth in Section A.2 of this Exhibit for failure to provide notification within two (2) hours of discovery.

29. Corrective Action Plan Response

If Contractor fails to provide a timely and acceptable corrective action plan or comply with corrective action plans as required by the State, Contractor shall pay liquidated damages in the amount of four hundred dollars ($400) per day for a late corrective action plan response, two thousand, three hundred and ten dollars ($2,310) for failure to provide an acceptable corrective action plan response, and four hundred dollars ($400) per day for failure to comply with an accepted corrective action plan response.

30. FSSA Required Trainings

The Contractor shall ensure that any MCE staff member given a FSSA email completes all FSSA required trainings. Unless an alternative deadline is identified by FSSA for a specific training, all FSSA required trainings must be completed by its respective due date. The Contractor may request additional time to complete but FSSA is under no obligation to grant extensions.

EXHIBIT 2B

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

B. Pay for Outcomes Program

1. Program Establishment and Eligibility

FSSA has established a pay for outcomes program under which Contractor may receive additional compensation if certain conditions are met. The state encourages plans to share earned incentive payments with members and providers. The compensation under the pay for outcomes program is subject to Contractor's complete and timely satisfaction of its obligations under the Contract. This includes but is not limited to timely submission of the Contractor's CAHPS and HEDIS Reports for the measurement year and the Certified HEDIS Compliance Auditor's attestation, as well as timely submission of the reports listed in Section A.5 of this Exhibit. In furtherance of the foregoing and not by limitation, the Contractor may, in FSSA's discretion, lose eligibility for its compensation under the pay for outcomes program if:

a. FSSA has suspended, in whole or in part, capitation payments or enrollment to the Contractor;

b. FSSA has assigned, in whole or in part, the membership and responsibilities of Contractor to another participating managed care plan contractor;

c. FSSA has assumed or appointed temporary management with respect to the Contractor;

d. The Contract has been terminated;

e. The Contractor has, in the determination of the Director of the Office of Medicaid Policy and Planning, failed to execute a smooth transition at the end of the Contract term, including failure to comply with the MCE responsibilities set forth in the Scope of Work; or

f. Pursuant to the Contract, including without limitation this Exhibit, FSSA has required a corrective action plan or assessed liquidated damages against Contractor in relation to its performance under the Contract during the measurement year.

FSSA may, at its option, reinstate Contractor's eligibility for participation in the pay for outcomes program once Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract, and FSSA has satisfactory assurances of acceptable future performance.

In accordance with 42 CFR 438.6(b)(2)(i)-(iv), withhold and incentive arrangements are for a fixed period of time and are measured during the rating period under the Contract in which the arrangements are applied. Withhold and incentive arrangements are not renewed automatically, are available to both public and private contractors under the same terms of performance, and do not condition Contractor participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements. All withhold and incentive arrangements are necessary for the specified activities, targets, performance measures, or quality based outcomes that support program initiatives as specified in the State's quality strategy in accordance with 42 CFR 438.6(b)(2)(v), 42 CFR 438.6(b)(3)(i)-(v), and 42 CFR 438.340.

2. Incentive Payment Potential

a. Withhold

During each measurement year, FSSA will withhold a portion of the approved capitation payments from Contractor as follows:

Year 1, 2023 – one point eight zero percent (1.80%)

Year 2, 2024 – one point eight five percent (1.85%)
Year 3, 2025 – one point nine zero percent (1.90%)
Year 4, 2026 – one point nine five percent (1.95%)
Year 5, 2027 – two point zero percent (2.00%)
Year 6, 2028 – two point one zero percent (2.10%)

Capitation payments will be withheld separately for the Contractor's HIP line of business. Contractor shall be eligible to receive some or all of the withheld funds based on Contractor's performance in the areas outlined in Section B.4.a of this Exhibit. Withhold payments will be calculated as set forth in Section B.4.a of this Exhibit. The State reserves the right to adjust performance measures and targets in future Contract years.

b. Additional Maternity Payments and Incentives.

FSSA will reimburse Contractor $60 for each Notification of Pregnancy (NOP) form completed and submitted to FSSA in accordance with the standards set forth by the State. This payment will be made on a monthly basis with capitation payments. The Contractor must distribute the entire $60 payment to the physician that completed the NOP form on behalf of the pregnant member.

NOP forms must be submitted in the form and manner set forth by FSSA. Reimbursement is limited to one NOP form per member, per pregnancy, regardless of whether the member receives pregnancy services through the HIP program. In order to qualify for reimbursement, the NOP form must meet standards set forth by FSSA.

3. Outcome Measures and Incentive Payment Structure

The outcome measures, targets, and incentive payment opportunities are outlined below. Outcome measures and targets are based on priority areas established by FSSA and data available in year one (1) of the contract. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. Outcome measures and priorities may change with the findings of the annual External Quality Review. Note that if a performance measure is retired during the course of a year, the State, at its sole discretion and in consultation with the Contractor, may replace the performance measure for that performance period. The performance measures and targets applicable during subsequent years of the Contract will be established annually by FSSA and reflected in an amendment to the Contract.

4. Performance Measures and Incentive Payment Structure

Contractor performance shall be calculated based on care delivered during the calendar year. The State reserves the right to make incentive payments, for any measure, be conditioned upon Contractor substantially maintaining or improving Contractor's outcome on that individual measure from the previous year. If the State exercises this right, the Contractor will be eligible for incentive payments if Contractor outcomes on individual measures for a certain year decline from the previous year's outcomes by a de minimis amount defined by FSSA for each measure. Future incentive payments for any measure may be conditioned upon Contractor maintaining or improving Contractor's outcome from the prior year.

Measures will be paid based on custom specifications and performance will be determined by FSSA or its designee. Contractor shall submit information to FSSA, in the format and detail specified by FSSA, with respect to each performance measure set forth below. Any data received after the required submission date will not be eligible for an incentive payment. The amount of performance withhold at risk for pay for outcomes measures will be established for the first year of the contract and reviewed annually thereafter. The amounts set for 2023 and any

changes year over year will be at the sole discretion of the State. Annual adjustment to withhold percentages may occur to reflect OMPP priorities.

For each performance measure, it is anticipated that there will be three (3) tiers of withhold available to be earned. Rates will be set based upon the priority measure for the Contractor to earn fifty percent (50%), seventy-five percent (75%), or one hundred percent (100%) of the amount of the Performance Withhold at risk. Contractor is eligible to receive its incentive payment based on measurement year rate regardless of prior year performance.

a. Incentive Payments – Withholds – HIP

The following incentives are payable in the form of release of funds withheld. For purposes of this subsection only, the amount withheld shall be referred to as the "Performance Withhold." The amount of the Performance Withhold at risk varies by measure. The amounts of Performance Withhold at risk listed below are rounded to the nearest hundredth decimal point.

i. *Adult preventive care*

Percentage of members twenty (20) years and older who had a preventive care visit. HEDIS® Adult Preventive Care measure (AAP) using administrative data.

Amount of Performance Withhold at risk: 15%

If Contractor's 2025 measurement year rate is at or above the 25th percentile and below the 50th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the 50th percentile and below the 75th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the 75th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

ii. *Completion of Health Needs Screenings for New Members*

Administrative reporting for completion of health needs screenings defined in the reporting template as "% Screened (all except Terminated)." It is the calculation of the percentage of newly enrolled MCE members, net of terminated members that have had a health needs screening completed within ninety (90) days.

Amount of Performance Withhold at risk: 10%

If Contractor's 2025 measurement year rate is at or above sixty percent (60%) screened and below sixty-five (65%) screened, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above sixty-five percent (65%) screened and below 70% screened, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above seventy percent (70%) screened, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

iii. *Follow-Up After Hospitalization for Mental Illness (HEDIS ® FUH)*

The percentage of discharges for members six (6) years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates will be evaluated:

1) The percentage of discharges for which the member received follow-up within thirty (30) days after discharge.

2) The percentage of discharges for which the member received follow-up within seven (7) days after discharge.

Amount of Performance Withhold at risk: 15% for each rate reported for a total of 30%

Rates 1 and 2 will be paid out separately as described below:

If Contractor's 2025 measurement year rate is at or above the 50th percentile and below the 66th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the 66th percentile and below the 75th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the 75th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

iv. *Post-partum visits (HEDIS ® PPC 2)*

Percentage of deliveries that had a postpartum visit on or between seven (7) and eighty-four (84) days after delivery. Includes deliveries of live births on or between October 8th of the year prior to the measurement year and October 7th of the measurement year.

EXHIBIT 2B

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Amount of Performance Withhold at risk: 10%

If Contractor's 2025 measurement year rate is at or above the 25th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the 50th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the 75th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

v. ***Timeliness of Ongoing Prenatal Care (HEDIS ® PPC 1)***

Percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within forty-two (42) days of enrollment in the organization. Includes deliveries of live births on or between October 8th of the year prior to the measurement year and October 7th of the measurement year.

Amount of Performance Withhold at risk: 10%

If Contractor's 2025 measurement year rate is at or above the 50th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the 66th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the 75th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

vii. ***Prenatal Depression Screening and Follow-Up (PND-E)***

The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. HEDIS® ECDS Prenatal Depression Screening and Follow-Up measure (PND-E)

Amount of Performance Withhold at risk: 10%

If Contractor's 2025 measurement year rate is at or above the 10th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the 25th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk

If Contractor's 2025 measurement rate is at or above the 50th percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

viii. *Pregnant Members Receiving Care Coordination*

Percentage of pregnant members assigned to the Contractor who were enrolled in and received care coordination services for thirty (30) or more days and had either an initial screening or comprehensive health assessment completed.

Total pregnant members assigned to each Contractor for the calendar year will be pulled from the Optum EDW. The Contractor will be required to send a listing of pregnant members who were enrolled in care coordination for thirty (30) or more days. The list will contain each pregnant member's name, the member ID number, date of initial screening or comprehensive health assessment completion, date of enrollment into care coordination, and date of disenrollment from care coordination.

Amount of Performance Withhold at risk: 5%

Contractor will receive twenty five percent (25%) of withhold if thirty percent (30%) or more of their assigned pregnant members were enrolled in and received thirty (30) days or more of care coordination during the calendar year and completed either initial assessment or comprehensive health assessment.

Contractor will receive fifty percent (50%) of the withhold if forty percent (40%) or more of their assigned pregnant members were enrolled in and received thirty (30) days or more of care coordination during the calendar year and completed either initial assessment or comprehensive health assessment.

Contractor will receive seventy five percent (75%) of the withhold if fifty percent (50%) or more of their assigned pregnant members were enrolled in and received thirty (30) days or more of care coordination during the calendar year and completed either initial assessment or comprehensive health assessment.

Contractor will receive one hundred percent (100%) of the withhold if sixty percent (60%) or more of their assigned pregnant members were enrolled in and received thirty (30) days or more of care coordination during the calendar year and completed either initial assessment or comprehensive health assessment.

ix. *Glycemic Status Assessment for Patients with Diabetes (HEDIS ®GSD)*

The percentage of members eighteen (18) to seventy-five (75) years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

Glycemic Status<8.0%

Amount of Performance Withhold at risk: 10%

If Contractor's 2025 measurement year rate is at or above the twenty-fifth (25th) percentile and below the fiftieth (50th) percentile of NCQA 2026 Quality Compass,

Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the fiftieth (50th) percentile and below the seventy-fifth (75th) percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2025 measurement year rate is at or above the seventy-fifth (75th) percentile of NCQA 2026 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

b. Auto-Assignment Incentive

Effective at the start of this contract, and on a state fiscal year basis annually thereafter, the State shall adjust the auto-assignment methodology rotation based on Contractor's relative percent of the total amount of the Performance Withhold at risk earned in the previous complete calendar year. The State reserves the right to consider factors such as Contractor performance on clinical quality outcomes as reported through HEDIS data, enrollee satisfaction as delineated through the CAHPS survey results, network access and other outcome measures in adjustment of the auto-assignment methodology.

The Contractor who receives the highest percent of the amount of the Performance Withhold at risk will receive a higher percentage of all auto-assigned members in the subsequent calendar year. The remaining Contractors will receive lower proportionate shares of all auto-assigned members in the subsequent calendar year.

In the event more than one MCE achieves the same percentage of the total amount of the Performance Withhold at risk, the total percentage of auto-assignment members available to each based on their relative performance as set forth above will be divided between the tied MCEs.

5. Timing of Payments

a. Performance Outcomes and Targets

FSSA will make its best efforts to distribute a report identifying Contractor's performance for the calendar year before the end of the first quarter of the calendar year following the close of the HEDIS cycle for each outcome measure identified in Sections B.4 and B.5. FSSA will make its best efforts to distribute payment to Contractor, subject to Section B.8 below, by March 31. For example, for a pay for performance measure for year 2024, the Contractor would be paid by the end of the first quarter of 2026.

b. NOP Forms

NOP payments of $60 will be made with capitation payments.

6. Conditions to Incentive Payments

FSSA will not have any obligation to distribute the Contractor's incentive payment to Contractor if FSSA has made a determination that Contractor is not eligible to participate in the pay for performance program, as described in Section B.1 above. The State encourages plans to share earned incentive payments with member and providers.

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CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

7. Disposition of Undistributed Incentive Payment Funds

In the event the maximum amount of the incentive payment funds available to all managed care plan contractors is not earned and distributed based on the performance of Contractor and/or other managed care plan contractors, FSSA will retain the difference (hereinafter referred to as the "undistributed incentive payment funds"). The undistributed incentive payment funds, which may include unearned withhold funds forfeited by other managed care plan contractors, may be available to Contractor to fund all or a portion of quality improvement initiatives proposed by Contractor, subject to the conditions set forth by OMPP for priorities identified in the OMPP Quality Strategy Plan. Such quality improvement initiatives may include, but are not limited to, healthcare IT initiatives (such as but not limited to incentives for provider adoption of electronic health records, e-prescribing and/or data sharing with the Indiana Health Information Exchange or other regional health information exchanges); cost and quality transparency initiatives; number of provider and member complaints handled; overall HEDIS scores; PMP access; behavioral health and physical health integration initiatives; timeliness of claims payment; and clinical initiatives.

The Director of the Office of Medicaid Policy and Planning must approve requests for any initiatives proposed to earn undistributed incentive payments funds.

FSSA has full discretion to determine whether and the extent to which any such distributions will be made and the FSSA may choose not to award undistributed incentive payments funds.

8. Non-Financial Incentives

In addition to the potential to earn incentive payments based on performance in the identified areas, FSSA may establish other means to incent performance improvement.

FSSA retains the right to publicly report Contractor performance. Information which may be provided in public reports includes but is not limited to Contractor's audited HEDIS report, Contractor's Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, and information based on Encounter Data Quality submission or underlying encounter data submitted by Contractor. FSSA intends to distribute information on key performance indicators to participating managed care plan contractors and the public on a regular basis, identifying Contractor's performance, and comparing that performance to other managed care plan contractors, standards set by FSSA and/or external benchmarks or industry standards. FSSA may recognize managed care plan contractors that attain superior performance and/or improvement by publicizing their achievements. For example, FSSA may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. To the extent data is used in a public report, it must be received by stated deadline in order to be published.

In year two (2) of the Contract, FSSA intends to include Contractor quality and performance indicators on materials distributed to potential members to facilitate MCE selection. The State reserves the right to develop a rating system advertising Contractor performance on areas such as consumer satisfaction, network access and quality improvement.

Following the initial year of the Contract, after which sufficient quality data is anticipated to be available, the State seeks to reward high performing MCEs through the auto-assignment logic. For example, in developing the auto-assignment methodology, the State reserves the right to consider factors such as Contractor performance on clinical quality outcomes as reported through HEDIS data, enrollee satisfaction as delineated through the CAHPS survey results, network access and other outcome measures.

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EXHIBIT 3B

PROGRAM DESCRIPTIONS AND COVERED BENEFITS

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EXHIBIT 3B

PROGRAM DESCRIPTIONS AND COVERED BENEFITS

1.0 HIP Program Description & Covered Benefits

1.1 Overview of the Program

Medicaid is a federal-and state-funded health care program providing reimbursement for reasonable and necessary medical care for persons meeting eligibility requirements. The Indiana Family and Social Services Administration (FSSA) authorized by federally approved 1115 waiver, administers the Healthy Indiana Plan (HIP) program in Indiana. More detailed information about Indiana Health Coverage Programs (IHCP) is available on the State's website at http://www.indianamedicaid.com/.

1.2 Eligible and Excluded Populations

The State has sole authority for determining whether individuals or families meet any of the eligibility criteria of the HIP program. The FSSA Division of Family Resources (DFR) makes eligibility determinations.

The Healthy Indiana Plan (HIP) is a Medicaid expansion for individuals 19-64 years of age with annual household income of not more than 138% of the federal poverty level (FPL), as calculated based on the Modified Adjusted Gross Income (MAGI) guidelines with 5% income disregard. All individuals eligible for HIP, with the exception of Native Americans, must enroll in managed care.

Additional eligibility criteria are set forth in IC 12-15-44.2 and 405 IAC 10-4, as may be amended. The following individuals are not eligible for HIP:

- An individual who participates in the federal Medicare program; and
- An individual who qualifies for Medicaid under another aid category, with the exception of (i) the adult group under 42 CFR 435.119; (ii) pregnant women who choose to remain in HIP during the pregnancy; (iii) parents & caretaker relatives eligible under 42 CFR 435.110; (iv) low-income individuals who are at least nineteen (19) years of age and less than twenty-one (21) years of age and eligible under 42 CFR 435.222; or (v) transitional medical assistance.

1.3 Delivery System

Managed care entities (MCEs), which include both Indiana-licensed accident and sickness insurers and health maintenance organizations (HMO)s, contract with FSSA to provide covered services to HIP enrolled members. The MCEs manage care through a contracted network of PMPs, specialists, and other providers.

The State requires MCEs to initiate network development. The State will evaluate the Contractor's progress in its network development efforts prior to the start date of the Contract. FSSA reserves the right to limit the enrollment, by county, of a particular MCE, in order to ensure the members have adequate choice of plans.

1.4 HIP Covered Services and Benefit Package

The HIP program covers the benefits set forth below.

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PROGRAM DESCRIPTIONS AND COVERED BENEFITS

HIP covered benefits include physician services, behavioral health services, inpatient and outpatient care, emergency services, preventive care services, family planning services, hospice, pharmacy services, DME, diagnostic services and therapies, disease management and home health, as set forth in 405 IAC 10-7, as may be amended.

Table 1 provides a general list of the HIP covered services and limitations and identifies whether each service is reimbursed by the MCEs. Contract Exhibit 1.B, Scope of Work and HIP MCE Policies and Procedures Manual describe the benefits and services in greater detail including, but not limited to, the following:

- Services that are covered under HIP.
- Self-referral services that include but are not limited to family planning services, psychiatric services, diabetes self-management services, emergency services, urgent care, and behavioral health services.
- Medicaid services excluded from HIP are long-term institutional care and Home and Community Based waiver services.
- Non-covered services are set forth in 405 IAC 10-7.
- In accordance with 42 CFR 438.6(f)(2)(i), which sets forth compliance requirements between MCEs and FSSA, payment shall not be made for provider-preventable conditions (PPCs).

TABLE 1. HEALTHY INDIANA PLAN BENEFITS

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Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Ambulatory Patient Services			
Primary Care Physician (PCP) Services Office Visit		Services include but not limited to medical and second opinion consultations.	Yes
Specialty Physician Visits		Referral physician office visit included.	Yes
Home Health Services	100 visits per year.	Services include but not limited to nursing care given or supervised by RN and nutritional counseling.	Yes
Outpatient Surgery		Includes diagnostic invasive procedures that may or may not require anesthesia.	Yes
Allergy Testing		Includes allergy procedures-administration of serum.	Yes
Chemotherapy-Outpatient		Includes therapeutic injections which are medically necessary and may not be self-administered.	Yes
IV Infusion Services			Yes
Radiation Therapy- Outpatient			Yes
Dialysis		Coverage provided for home dialysis services.	Yes
Non-Surgical Treatment Option Morbid Obesity	6 visits per calendar year for program.	Covered service for enrollment in a physician-supervised weight loss treatment program when referred by your physician.	Yes
Outpatient Services		Includes colonoscopy and pacemaker. Benefits provided are PCP, specialty, and referral for all physician services in an outpatient facility.	Yes
Clinical Trials for Cancer Treatment	Items and services that are not routine care costs or unrelated to the care method will not be covered.	The clinical trial must be approved or funded by an approved entity. Coverage provided for routine care costs that are incurred in the course of a clinical trial.	Yes
Dental- Limited Covered Services- Accident/Injury	Treatment complete within 1 year from initiation; Coverage not provided for orthodontia, dental procedures, repair of injury caused by an intrinsic force, repair of artificial teeth, dentures, or bridges and other dental services.	Injury to sound and natural teeth including teeth that have been filled capped or crowned.	Yes
Urgent Care- Walk-ins		Coverage includes after hours care.	Yes

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PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Routine Foot Care	6 visits per year; Coverage not provided for supportive devices of the feet, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions and calluses.	Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases.	Yes
Voluntary Sterilization for Males			Yes
Emergency Services			
Emergency Department Services	Medical care provided outside of the U.S. is not covered.	Emergency room included.	Yes
Emergency Transportation: Ambulance/Air Ambulance		Other medically necessary ambulance transport (ambulance, medi-van or similar medical ground, air or water transport to or from the hospital or both ways and transfer from a hospital to a lower level of care) is covered when ordered by your PCP.	Yes
Hospitalization			
General Inpatient Hospital Care	Benefit does not include personal comfort items and room and board when temporary leave permitted.	Services include but not limited to intensive care unit/coronary care unit; inpatient cardiac rehabilitation; and inpatient rehabilitation therapy.	Yes
Inpatient Physician Services		Benefit includes PCP, specialty and may require referral for physician services in the hospital.	Yes
Inpatient Surgical Services	Benefit does not include personal comfort items and room and board when temporary leave permitted.	Surgical operations may include replacement of diseased tissue removed while a member.	Yes
Non-Cosmetic Reconstructive Surgery	Services begin within 1 year of the accident; Benefit does not include personal comfort items and room and board when temporary leave permitted.	Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident occurring while a member.	Yes
Mastectomy- Reconstructive Surgery	Benefit does not include personal comfort items and room and board when temporary leave permitted.		Yes

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PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Transplants		Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a member. Specialty Care Physician (SCP) provides pre-transplant evaluation. Non-experimental, non-investigational organ and other transplants are covered. The Contractor shall not pay for organ transplants unless the Contractor follows the written standards included in the State Plan that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to members. For additional information, please see the following: • https://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_3/3.1e.pdf • https://provider.indianamedicaid.com/ihcp/StatePlan/Section_3/3.1.f.g.h.pdf	Yes
Congenital Abnormalities	Benefit does not include personal comfort items and room and board when temporary leave permitted.		Yes
Anesthesia		Includes anesthesia services and supplies.	Yes
Hospice Care	Room and board services are not covered when temporary leave permitted.	Hospice care provided if terminal illness, in accordance with a treatment plan before admission to the program. Treatment plan must provide statement from physician that life expectancy is 6 months or less. Concurrent care is provided to children (19 & 20 year olds).	Yes (including hospice in an institutional setting)
Medical Social Services		Assist member and family in understanding and coping with emotional and social problems affecting health status.	Yes
Dialysis			Yes
Chemotherapy			Yes
Radiation Therapy			Yes
Inpatient Cardiac Rehabilitation	90 days annual maximum.		Yes

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Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Inpatient Rehabilitation Therapy	90 days annual maximum.	Coverage includes physical, occupational, speech and pulmonary therapy of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning.	Yes
Maternity and Newborn Care			
Maternity Care	The benefit provides for antepartum services up to 14 visits for normal pregnancies. High-risk pregnancies may allow for additional visits. Postpartum services include 2 visits within 60 days of delivery.	Coverage is provided from the State Plan and includes various obstetrical services such as antepartum and postpartum visits, laboratory and x-ray (ultrasound) services and other services.	No
Maternity-Delivery		Coverage is provided from the State Plan.	No
Pregnancy Benefits			
Chiropractic Manipulations - Pregnancy Benefit	Limits equivalent to State Plan.	Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage is limited to services related to pregnancy, conditions that may complicate the pregnancy or urgent care services.	No
Non-emergency Transportation - Pregnancy Benefit		Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage is provided subject to program restrictions.	No
Medicaid Rehabilitation Option (MRO) - Pregnancy Benefit		Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. MRO services are designed to assist in the rehabilitation of the consumer's optimum functional ability in daily living activities.	No

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PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Dental Services - Pregnancy Benefit	Limits equivalent to State Plan.	Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The dental benefits include State Plan equivalent benefits.	No
TMJ - Pregnancy Benefit Basic Plan		Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan.	No
Adult Vision - Pregnancy Benefit Basic Plus	Limits equivalent to State Plan.	Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The dental benefits include State Plan equivalent benefits.	No
Health Education – Smoking Cessation and Tobacco Dependence Treatment - Pregnancy Benefit	Reimbursement is available for pharmacotherapy treatment for up to 180 days per member per calendar year. Pharmacotherapy treatment after 180 days requires documentation for medical necessity. There are no service limits on tobacco cessation counseling sessions.	Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan.	No
Mental Health and Substance Use Disorder Services including Behavioral Health Treatment			
Mental/Behavioral Health Inpatient	Benefits do not include personal comfort items and room and board when temporary leave available.		Yes
Mental/Behavioral Health Outpatient	Coverage does not include self-help training or other related forms of non-medical self-care.	Coverage applies to individual therapy and group therapy sessions.	Yes
Substance Abuse Inpatient Treatment	Benefit does not include services and supplies for the treatment of co-dependency or caffeine addiction, personal comfort items, and room and board when temporary leave permitted.		Yes

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PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Substance Abuse Outpatient Treatment	Benefit does not include services and supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction.	Coverage includes detoxification for alcohol or other drug addiction.	Yes
Prescription Drugs			
Generic and Brand Name Formulary	Select drugs are carved out of the HIP capitation rates for CY 2024 (full rating period). Below is a list of the drugs that have been carved out: • Designated drugs: ○ Under the pharmacy benefit- Drugs listed in *Drug Therapies Carved-Out of the Managed Care Pharmacy Benefit*, accessible from the Carved-out Pharmacy Benefit Drugs quick link on the OptumRx Indiana Medicaid website ○ Under the medical benefit- Drugs listed in *Physician-Administered Drugs Carved out of Managed Care and Reimbursable Outside the Inpatient Diagnosis-Related Group*, accessible from the Code Sets page at https://www.in.gov/medicaid/providers/	The formulary covers at least the same level of services as the base benchmark pharmacy benefit, including one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater. This benefit is provided through the Managed Care Entities, and the exact drugs covered under the formulary may vary by MCE. The MCE must offer additional pharmacy services for the HIP Plus and HIP State Plan Plus plans, including (i) 90-day prescription supplies; (ii) mail order pharmacy benefit; and (iii) medication therapy management (MTM) services.	Yes
Rehabilitative and Habilitative Services			

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Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Physical Therapy, Occupational Therapy, Speech Therapy	60 (Basic Plan); 75 (Plus Plan) combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.		Yes
Durable Medical Equipment (DME)	15-month rental cap; 1 every 5 year per member- replacement; DME does not include corrective shoes, arch supports, and other non-durable supplies. Equipment not suitable for home use is a non-covered benefit.	Benefit includes but not limited to wheel chairs, crutches, respirators, traction equipment, hospital beds, monitoring devices, oxygen-breathing apparatus, and insulin pumps. Training for use of DME is also covered and applicable rental fees.	Yes
Prosthetics	Benefit does not include foot orthotics and devices solely for comfort or convenience.	Covered services include the purchase, replacement, or adjustment of artificial limbs when required due to a change in your physical condition or body size due to normal growth.	Yes
Corrective Appliances	Benefit does not include but not limited to artificial or prosthetic limbs, cochlear implants, or dental appliances.	Benefit includes but not limited to hemodialysis equipment, breast prostheses, back braces, artificial eyes, one pair eyeglasses due to cataract surgery, ostomy supplies, and prosthetics (all prosthetics except prosthetic limbs.)	Yes
Cardiac Rehabilitation	60 (Basic Plan); 75 (Plus Plan) combined visits annually for PT, OT, ST, and pulmonary rehabilitation.	Benefit includes services for the improvement of cardiac disease or dysfunction.	Yes
Medical Supplies	Benefit does not include non-durable supplies and/or convenience items.	Benefit includes casts, dressings, splints, and other devices used for reduction of fractures and dislocations.	Yes
Pulmonary Rehabilitation	60 (Basic Plan); 75 (Plus Plan) combined visits annually for PT, OT, ST, and cardiac rehabilitation.		Yes
Skilled Nursing Facility (SNF)	100 days per benefit period; Room and board services are not covered when temporary leave permitted.	Services include but not limited to medical social services and short-term physical, speech and occupational therapies (subject to limits).	Yes
Autism Spectrum Disorder Services	60 (Basic Plan); 75 (Plus Plan) combined visits annually for PT, OT, ST and pulmonary rehabilitation.	Benefit provides coverage for Asperger's syndrome and autism. Coverage for services is provided as prescribed by the treating physician in accordance with the treatment plan.	Yes
Hearing Aids	1 per member every 5 years.		Yes

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PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Home Health: Medical Supplies, Equipment and Appliances	Benefit does not include non-durable supplies and/or convenience items.		Yes
Laboratory Services			
Lab Tests	Coverage does not include lab expenses related to physical exams when provided for employment, school, or other similar purposes.		Yes
X-rays	Coverage does not include lab expenses related to physical exams when provided for employment, school, or other similar purposes.		Yes
Imaging- MRI, CT, and PET		Coverage also includes MRA and SPECT scan.	Yes
Pathology			Yes
Radiology			Yes
EKG and EEG			Yes
Preventive and Wellness Services and Chronic Disease Management			
Preventive Care Services		Physician services for wellness and preventive services include but are not limited to routine physical exam, routine total blood cholesterol screening, routine gynecological services, and routine immunizations. Includes (1) all preventive items or services that have a rating of 'A' or 'B' by the United States Preventive Task Force (USPSTF); (2) Immunizations recommended for the individuals age and health status by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); (3) for infants, children, adolescents and adults, preventive care and screenings included in the Health Resources and Services Administration's (HRSA) Bright Futures comprehensive guidelines, and (4) preventive screenings for women as recommended by the Institute of Medicine (IOM).	No

EXHIBIT 3B

PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Diabetes Self Management Training		Covered services are limited to physician authorized visits after receiving a diagnosis of diabetes; after receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management; and for re-education or refresher training.	No
Health Education	3 visits for classes in nutrition or smoking cessation and tobacco dependence treatment when referred by your physician.		No
Routine Prostate Specific Antigen (PSA) Test	One test annually for an individual who is at least 50 years old or less than 50 if at high risk.		No
Pediatric Services including Oral and Vision Care			
EPSDT Benefits	EPSDT is required in the ABP for 19 and 20 year olds.	Services provided under EPSDT may include preventive and diagnostic services that are medically necessary and may need continued treatment.	Yes/No (Depends on type of service received.)
Other Covered Benefits- Plus Plan			
Dental Coverage		The dental benefits include evaluations and cleanings (2 per person per benefit year); bitewing x-rays (4 x-rays per person per benefit year); comprehensive x-rays (1 complete set every 5 years); minor restorative services, such as fillings (4 per person per benefit year); and major restorative services, such as crowns (1 per person per benefit year).	Yes

EXHIBIT 3B

PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Adult Vision		The vision benefits include routine exam (1 every 2 years); eyeglasses, including frames and lenses (1 pair every 5 years if there is not a sufficient change in prescription (vision), loss, irreparable damage, or theft); frames include but not limited to plastic or metal; replacement eyeglasses (covered when medical necessity guidelines met or due to loss, theft or damage beyond repair); contact lenses (covered for medical necessity, such as facial deformity or allergy to frame prevents wearing eyeglasses); vision surgeries (covered for medical necessity); and vision training therapies (covered for medical necessity. Not all frames and lenses are covered, unless medically necessary. Members may choose to upgrade frames and lenses and pay the difference.	Yes
Temporomandibular Joint (TMJ)		Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage includes treatment of temporomandibular joint (TMJ) disorder. For authorization, the Contractor may require prior authorization requirements, such as general member information, documentation of non-surgical treatment and duration prior to surgery and a justification of services rendered for the medical needs and circumstances of the member.	Yes

EXHIBIT 3B

PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Bariatric Surgery	Benefits do not include personal comfort items and room and board when temporary leave available.	To be eligible for this benefit the member must: (1) have morbid obesity that has persisted for at least five years duration, and Physician-supervised non-surgical medical treatment has been unsuccessful for at least 6 consecutive months; or (2) successfully achieve weight loss after participating in physician-supervised non-surgical medical treatment but has been unsuccessful at maintaining weight loss for two years [> 3 kg (6.6 lb.) weight gain].	Yes
Chiropractic Manipulations	Limited to one (1) unit per day and six (6) units per covered person per benefit year.	• Self-referral – Provider referral is not required. • No prior authorization is needed • Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of practice chiropractic	Yes

EXHIBIT 4A

RESPONSIBILITIES OF THE STATE – HEALTHY INDIANA PLAN

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EXHIBIT 4A

RESPONSIBILITIES OF THE STATE – HEALTHY INDIANA PLAN

1.0 Activities of the State and Its Agents

Medicaid is a federal- and state-funded health care program providing payment for reasonable and medically-necessary care for persons meeting eligibility requirements. Each state administers its own program in accordance with federal requirements. In Indiana, the Indiana Family and Social Services Administration (FSSA), administers the Medicaid program, which includes the Healthy Indiana Plan (HIP). Other state agencies interface with FSSA in administering and managing the HIP programs.

2.0 Medicaid Application and Eligibility Determination

Individuals will be able to apply for the HIP program through the Division of Family Resources (DFR) and other authorized enrollment centers. DFR is responsible for determining if persons are eligible. DFR is also responsible for calculating POWER Account contributions.

2.1 Eligibility Redetermination

The State reserves the right to modify HIP plan design, including cost-sharing and eligibility components, in accordance with federal and State guidance. HIP eligibility redetermination will occur every twelve (12) months. In accordance with Indiana Code 12-15-44.5-4.9(b), the State seeks to implement a member specific open enrollment period, whereby members who lose eligibility due to failure to comply with redetermination process will be required to wait six (6) months until their next open enrollment period to re-enroll in HIP coverage.

HIP members will be required to complete the annual redetermination process within the required timeframes. Approximately 45 days prior to the expiration of their 12-month eligibility period, each member will be notified of the upcoming redetermination and may be asked to submit documentation necessary for the State to determine continued eligibility. If required documentation is not provided prior to the expiration of the current eligibility period, the member will be disenrolled from HIP.

Members who do not return required information before the eligibility period end date, will be able to reenroll in HIP without a new application once they submit requested redetermination documents. However, after a 90-day period, the member will be required to wait three (3) months, or six (6) months from the initial date of disenrollment, until their next open enrollment before being permitted to reenroll in HIP. Ultimately, all HIP members are given a total of 135 days (45 days before the end of their eligibility period and 90 days after their eligibility period end date) to comply with the redetermination requirements.

The open enrollment policy does not apply to members who are medically frail, pregnant, low-income parents and caretakers, or low-income 19 and 20-year-old dependents. In addition, individuals who experience a change in circumstances which prevented completion of their redetermination process (as detailed in 405 IAC 10-10-13(E)) are also exempt from the open enrollment period and may reapply at any time.

3.0 Member Enrollment and Linkage to MCE

Applicants for the HIP programs will have an opportunity to select a Managed Care Entity (MCE) on their application. MCEs are expected to conduct marketing and outreach efforts to raise awareness of both the programs and their product. The Enrollment Broker is available to assist members in choosing an MCE. Once a member is fully enrolled and eligible to receive benefits from an MCE, their assignment to that MCE lasts for the remainder of the calendar year.

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RESPONSIBILITIES OF THE STATE – HEALTHY INDIANA PLAN

Members will have an opportunity to change MCEs each year during the open enrollment period that will occur between November 1st and December 15th.

Applicants who do not select an MCE on their application will be auto-assigned according to the State's auto-assignment methodology.

The State's enrollment policies and procedures prohibit discriminating against individuals eligible to enroll on the basis of race, color, national origin, health status or the need for health care services, in accordance with 42 CFR 438.6(d). The MCE may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs or a change in a member's health care status. Further, a member's health care utilization patterns may not serve as the basis for disenrollment from the MCE. MCEs must not discriminate against individuals eligible to enroll on the basis of race, color, national origin, ancestry, disability, age, sex, sexual orientation, gender identity, or religion and must not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, ancestry, disability, age, sex or religion.

3.1 Enrollment Broker Services

The Helpline staff shall educate potential members about the benefits of primary and preventive care, the differences between the MCE options available to the potential member and the importance of choosing a PMP once enrolled in an MCE and establishing the PMP and member relationship. Enrollment education must include, but not necessarily be limited to the items noted below:

- Basic features of managed care.
- How to access the Medicaid health care system appropriately (i.e., keeping appointments, appropriate use of the emergency room, prior authorization requirements, understanding MCE rules, how to file a grievance, etc.).
- The importance of primary and preventive care and other health promotion services.
- Detailed, unbiased information about the MCEs (to be developed in concert with the MCEs and FSSA).
- Where applicable, how to access the transportation benefits within the MCEs rules.

3.2 Auto-assignment to MCE

For HIP eligible members who do not select an MCE on the application, the State fiscal agent will auto-assign the individual to an MCE. The rules and logic for auto-assignment are created by the State and comply with 42 CFR 438.52(f).

The State maintains an auto-assignment logic which considers established provider relationships. The State also anticipates establishing a rotating assignment methodology among all MCEs for members who cannot be matched to an MCE based on established provider relationship or family member assignment. In accordance with 42 CFR 438.56(g), the State will automatically reenroll with the MCE beneficiaries who are disenrolled solely because of the loss of eligibility for a time period of two (2) months or less.

Following the initial year of the Contract, after which sufficient quality data is anticipated to be available, the State seeks to reward high performing MCEs through the auto-assignment logic. For example, in developing the auto-assignment methodology, the State reserves the right to consider factors such as MCE performance on clinical quality outcomes as reported needs reformatting through Healthcare Effectiveness Data and Information Set (HEDIS) data, enrollee satisfaction as delineated through the Consumer Assessment of Healthcare

Providers and Systems (CAHPS) survey results, network access and other outcome measures. The State reserves the right to amend the auto-assignment logic.

The State maintains eligibility records in the Indiana Eligibility Determination Services System (IEDSS), the State's eligibility management information database. The State transmits eligibility data daily to the Medicaid management information system (MMIS) and *Core*MMIS. The MMIS system identifies HIP eligible members who did not select an MCE on their application and assigns them to an MCE according to the State's auto-assignment methodology.

The State reserves the right to amend the auto-assignment logic and may incorporate HEDIS or other quality indicators into the auto-assignment logic at a future date.

3.3 POWER Account Contributions

After an individual to MCE linkage occurs, either by self-selection or auto-assignment, individuals eligible for HIP must pay either their fast track pre-payment or initial POWER Account contribution, as applicable, before enrollment in the MCE is final. Notwithstanding the foregoing, individuals eligible for HIP with income at or below one-hundred percent (100%) of the federal poverty level (FPL) who do not make a fast-track pre-payment or initial POWER Account contribution within the sixty (60) calendar day due date in accordance with Section 13.7 of the Scope of Work will be enrolled in the HIP Basic or HIP State Plan Basic benefits effective the first day of the month in which non-payment was determined. The State reserves the right to modify HIP plan design, including cost-sharing and eligibility components, in accordance with federal and State guidance.

3.4 Enrollment of Newborns

Babies born to women enrolled in HIP are automatically eligible for Medicaid benefits for one year from the baby's date of birth. If the woman is enrolled in an MCE on the newborn's date of birth, the baby is assigned to the woman's MCE, retroactive to the baby's date of birth, assuming the availability of an appropriate Primary Medical Provider (PMP) for the newborn. The MCE will receive the newborn's monthly capitation rate retroactively from the newborn's date of birth once eligibility for the newborn is established and the baby is enrolled with the MCE. The State fiscal agent will notify the mother in writing of the auto-assignment of the newborn.

If the newborn is not assigned to the mother's MCE due to the lack of pediatric panels slots in the mother's MCE, the newborn will remain in fee-for-service until the effective date of an assignment to another MCE. In these cases, claims for services from the baby's date of birth until assignment to an MCE will be the responsibility of the State fiscal agent on a fee-for-service basis.

The HIP MCE Policies and Procedures Manual provides more information regarding the Pre-Birth Selection and MCE selection and change process.

4.0 Enrollment Rosters

The State fiscal agent notifies each MCE of all members enrolled in the MCE. The State fiscal agent generates MCE Member Enrollment Rosters using information obtained from the DFR's IEDSS transmissions, and MCE assignments entered into the Indiana MMIS system. The MCE Member Enrollment Rosters provide the MCE with a detailed listing of all members for whom the MCE is or has been responsible and identifies each enrollee's benefit package. The enrollment roster also identifies deleted enrollees who appeared as eligible members on the previous roster, but whose eligibility terminated prior to the actual effective date with the MCE.

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The MCE is responsible for reconciling the eligibility rosters with capitation payments received and, for HIP members, the State's POWER Account contributions. If an MCE receives either eligibility information or capitation for a member, and/or the State's POWER Account contribution for a HIP member, the MCE is financially responsible for the member. The State fiscal agent's eligibility verification systems, which are updated daily, must be used in the event of any discrepancies. The MCE discovering eligibility/capitation/POWER Account contribution discrepancies shall notify the fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after the MCE receives the eligibility records.

Refer to the HIP MCE Policies and Procedures Manual for detail about the eligibility roster process.

5.0 MCE Member Enrollment Limitations

To ensure member choice of MCEs and availability of healthcare providers, the State will monitor MCE member enrollment in the region monthly. The State reserves the right to monitor the actual panel sizes of each of the MCE's providers. If the determination is made to restrict an MCE's enrollment, the State will notify the MCE in advance of implementing member enrollment limitations. The State may impede MCE member enrollment growth by one or more of the following methods:

- Excluding the MCE from receiving default auto-assignment.
- Excluding the MCE from receiving previous MCE auto-assignment.

The State will evaluate MCE member enrollment each month to determine when any of the member limitations may be lifted.

6.0 Member Disenrollment from the MCE

6.1 Calendar Year Member Lock-In

Members will be locked into an MCE for the duration of the calendar year in which the member made their first POWER Account contribution. However, 42 CFR 438.56 permits members to request disenrollment from the MCE for just cause at any time. Further, members identified as an American Indian/Alaska Native pursuant to 42 CFR 136.12 may disenroll from managed care at any time during the twelve (12) month benefit period and transfer to fee-for-service benefits through the State.

6.2 Changing MCEs

6.2.1 Changing MCEs for Just Cause

HIP members may change MCEs at any time for just cause. Members must file a grievance with their MCE before a determination will be made upon their just cause request. Just cause reasons include the reasons described in 42 CFR 438.56(d)(2)(iv), including, but not limited to, the following:

(1) Receiving poor quality care.
(2) Failure of the Contractor to provide covered services.
(3) Failure of the Contractor to comply with established standards of medical care administration.
(4) Lack of access to providers experienced in dealing with the member's health care needs.
(5) Significant language or cultural barriers.

(6) Corrective action levied against the insurer by the office.
(7) Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence.
(8) A determination that another insurer's formulary is more consistent with a new member's existing health care needs.
(9) A change in aid category.
(10) Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.
(11) If a member was not given the opportunity to select an MCE during the open enrollment period the member may change their MCE during the first 60 days of the new calendar year benefit period or within 30 days of enrollment in HIP if the member is transitioning from other Indiana Health Coverage Programs (IHCP) coverage.

6.2.2 Changing MCEs Without Cause – HIP

HIP eligible members are allowed to change MCEs either (i) before the member makes either a fast-track payment or their first POWER Account contribution, or (ii) upon enrollment in HIP Basic or HIP State Plan Basic in accordance with Section 13 of the Scope of Work, whichever occurs first. Once a member has made any payment to an MCE, the member is subject to the 12-month calendar year lock-in requirement. If the member disenrolls and re-enrolls in HIP within the same 12 month period they will have their most recent POWER Account and MCE assignment reinstated. The MCE must notify HIP eligible members in the Welcome Letter of their right to change MCEs according to the aforementioned policy. HIP members will also have an opportunity to change MCEs at the end of the twelve (12)-month calendar year benefit period during the months of November-December. Members will also be given an opportunity to change MCEs when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(3).

7.0 Disenrollment from the Programs

7.1 Disenrollment from HIP

Except for the reasons listed in Section 13.7 of the Scope of Work, members will be disenrolled from HIP for any one of the following reasons:

- The member fails to make the required monthly POWER Account contribution within sixty (60) calendar days of its due date, and the member has income greater than one-hundred percent (100%) FPL and is not otherwise eligible for HIP Basic benefits.[3]
- The member is determined ineligible for HIP at redetermination.
- The member becomes covered under another Medicaid program.
- Any other reason set forth in 405 IAC 10-4.
- The member moves out of State.
- The member is deceased.

[3] This contract element is contingent upon federal and State approval.

All approved member disenrollments will be effective no later than the required timeframes set forth in 42 CFR 438.56.

8.0 Provider Enrollment and Disenrollment

The State considers all providers as eligible to participate in HIP when the provider enrolls with the IHCP. All HIP providers must first be enrolled as IHCP providers before providing services to members. The State allows physicians to contract as PMPs, specialists, and ancillary providers in any number of MCEs.

9.0 Ongoing MCE Monitoring

FSSA reviews and monitors MCE performance on a regular basis and identifies non-compliance with program requirements and performance standards outlined in the Contract, the Scope of Work and all exhibits. FSSA conducts monitoring activities through site visits, document review, review of performance data and analysis of encounter claims data. FSSA reserves the right to change or modify the reporting requirements, evaluation instruments and enforcement policies, as necessary, at any time during the Contract period with sufficient notice to the MCEs resulting from its monitoring activities or changes in state or federal requirements.

FSSA, or duly authorized agents of the state or federal government, reserves the right to inspect, audit, monitor or otherwise evaluate the performance of the MCE or its subcontractors during normal business hours, at the MCE's or its subcontractors' premises. At a minimum, FSSA will conduct regular monthly on-site reviews, and these reviews may include an audit of financial or operational systems and data.

In addition, FSSA complies with the external quality review regulations for monitoring managed care organizations set forth in 42 CFR 438.350.

9.1 FSSA's Right to Audit and Monitor

The Contractor acknowledges the State's responsibility for overseeing the administration of healthcare services to Medicaid beneficiaries enrolled in the State of Indiana's Hoosier Healthwise and Healthy Indiana Plan (HIP) programs. Accordingly, nothing in this Contract shall be construed to limit FSSA's right or ability to audit and monitor the Contractor's performance of duties identified in the Scope of Work (Exhibit 1.B), as FSSA may audit and monitor Contractor or any subcontractors/vendors of Contractor at any time and in any manner prescribed in this Contract or under applicable law. The FSSA reserves the right to use vendor(s) to perform these functions on behalf of FSSA and the vendor(s), as FSSA's agent, shall not be required to sign separate Confidentiality Agreements, Business Associate Agreements, or any other document prior to obtaining access to Contractor's information unless so required by FSSA. The Contractor and its subcontractors/vendors shall timely respond to any audit or monitoring requests of FSSA and/or its agents. The failure of Contractor to timely, completely, and accurately respond to audit and monitoring requests may result fines or other sanctions being imposed by FSSA as identified in Exhibit 2.B, Contract Compliance and Pay for Outcomes.

9.2 Evaluating MCE Solvency

The Indiana Department of Insurance maintains the primary responsibility for monitoring the MCE's solvency and monitors the MCE's financial status.

In addition, FSSA monitors the MCE's solvency status in accordance with federal regulations described in 42 CFR 438.116 by requiring the submission of various financial data for review.

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10.0 Policies and Procedures Manual

The HIP MCE Policy and Procedure Manual can be found in the Bidders' Library.

11.0 Reporting Manual

The Reporting Manual can be found in the Bidders' Library.

12.0 Making Payments to the MCE

FSSA pays MCEs participating in HIP a monthly capitation payment for each enrolled member. For pregnant HIP members, FSSA also, upon submission of proper data, makes an additional payment for maternity deliveries. For HIP members, FSSA makes the State's POWER Account contribution payment. The HIP MCE Policies and Procedures Manual discusses the capitation payment process, Electronic Funds Transfer (EFT) and other related issues.

Capitation payments may only be made by the State and retained by the Contractor for Medicaid-eligible enrollees per 42 CFR 438.3(c)(2). Per 42 CFR 438.6(b)(1), applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, are described in the Contract and other Exhibits.

EXHIBIT 5B

CONTRACT DEFINITIONS

Listed below are definitions and acronyms used in Indiana managed care Contracts. The following terms, when used in a contract, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other sections of the Contract, the specific language in the Contract shall govern. In addition to these definitions, see Indiana Law: IC 12-7-2 Chapter 2. Definitions.

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2).

Actuary - An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. An actuary develops and certifies the capitation rates [42 CFR 438.2].

Adjudicated Claim - A claim that has been received and processed by the Contractor which resulted in a payment or denial of payment.

Administrative Cost - All costs to the Contractor related to the administration of this Contract that are non-medical in nature.

Adverse Benefit Determination - As defined in 42 C.F.R. §438.400(b).

Affiliate - Any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership, and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the Contractor.

Agency review - A post-hearing process conducted by the FSSA Office of Hearings and Appeals to determine whether the appeal process was properly conducted.

Agent - Any individual who has been delegated the authority to obligate or act on behalf of a provider. [42 CFR 455.101]

Aligned Enrollment - Refers to enrollment in a Dual Eligible SNP of full-benefit Dual Eligible Beneficiaries whose Medicaid benefits are covered under the Contractor's Medicaid contract and the Dual Eligible D-SNP's MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization.

Americans with Disabilities Act (ADA) - Public Law 101-336. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services.

American Indian or Alaska Native (AI/AN) enrollee - Any AI/AN individual eligible for services from an Indian health care provider.

Appeal - Per 42 CFR §438.400(b), a request for a review of an adverse benefit determination. An appeal is a special kind of complaint a member may make if they disagree with a decision to deny a request for health care services or payment for services they've already received. A member may also make a complaint if they disagree with a decision to stop services that they are receiving. For example, a member may ask for an appeal if Medicare doesn't pay for an item or

service they think they should be able to get. There is a specific process that a member's health plan must use when they ask for an appeal.

APS - Indiana's Adult Protective Services.

Area Agencies on Aging – Not-for-profit agencies around the state that provide case management, information and referrals to various services for persons who are aging or developmentally disabled.

Assessment - An analysis of a patient's needs to determine which services shall be provided to the patient.

Auto-assignment - Process that automatically assigns a managed care member to an MCE if the member does not select an MCE within the allotted time frame.

Behavioral Health Services – Mental health and/or substance abuse services collectively.

Benefit Appeal – As distinguished from an Eligibility Appeal, a "Benefit Appeal" concerns an enrollee's request to contest a Contractor's adverse benefit determination by receiving a State Fair Hearing (SFH).

Benefits - The package of health care services, including physical health and behavioral health, that define the covered services available to enrollees assigned to the Contractor pursuant to the Contract with Indiana.

Breach (with respect to Protected Health Information (PHI)) - The acquisition, access, use, or disclosure of protected health information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the protected health information.

Business Day - Monday through Friday, except for State of Indiana holidays.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) - Patient experience surveys that ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others.

Capitation Rate - The amount established as a fixed monthly payment per person, for which the Contractor provides a full range of covered services, pursuant to the rate setting methodology described in Exhibit 6.B of this Contract.

Care Coordinator - An individual meeting Indiana required residential, education, and/or experience requirements that is assigned to every member with the primary responsibility for coordination of the member's physical and behavioral health services.

Care Management - A level of direct-contact services tailored to the member that is intended to provide members with assistance with care coordination activities, making preventive care appointments, and/or accessing care for needed health or social services to address a member's chronic health condition(s). Care Management entails a purposeful plan to reach members and impact their health and health care utilization and to coordinate all services provided to members.

Carved-out Services - As defined by the State, include services that are carved out of managed care program coverage, meaning that they are the financial responsibility of the State to provide to managed care members via fee-for-service (FFS) Medicaid benefits. This definition also includes services that could potentially require a managed care member to be disenrolled from a managed care plan and instead be reenrolled into traditional Medicaid to obtain the FFS benefit.

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CONTRACT DEFINITIONS

CFR - Code of Federal Regulations. - The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

Choice Counseling - The provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among MCEs and PCPs. Choice counseling does not include making recommendations for or against enrollment into a specific MCE. [42 CFR 438.2]

Claim Dispute - A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Clean Claim - A claim received by the Contractor or adjudication that requires no further information, adjustment, or alteration by the provider of the services to be processed and paid.

Clinical Practice Guidelines – Systematically developed tools or standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances. Such guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

CMS – Centers for Medicare & Medicaid Services - The federal agency within the United States Department of Health and Human Services (HHS), which administers the Medicare (Title XVIII) and Medicaid (Title XIX) programs, and the State Children's Health Insurance Program (Title XXI).

Co-insurance - The portion of an allowed charge that a member would be required to pay for a covered medical service after the deductible has been met if the member did not have Medicaid coverage. The co-insurance or a percentage amount is paid by the Medicaid if the member is eligible for Medicaid.

Community Health Worker (CHW) - A person who meets the certification or experience qualifications required by the State to provide coordination of care and patient education services and care coordination in clinic and community settings for the purpose of disease prevention, promoting health, and increasing access to health care for individuals and their communities.

Consumer-Directed Worker - An individual who has been hired by a member participating in consumer direction or his/her representative to provide one or more eligible home and community-based services to the member. Does not include an employee of an agency that is being paid by a Contractor to provide services to the member.

Contractor - A managed care entity (MCE) organization or entity that has a prepaid capitated contract with the State of Indiana to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements and State and Federal law, rule, regulations, and policies.

Convicted - A judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Copayment or Copay - Per IC 27-13-1-8, copayment means an amount, or a percentage of the charge, that an enrollee must pay to receive a specific service that is not fully prepaid.

Corrective Action Plan (CAP) - A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality

Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

Cost Avoidance - The process of identifying and utilizing all confirmed sources of first- or third-party benefits before payment is made by the Contractor.

Covered Services – Pursuant to this contract, services individuals in this program will receive include all traditional Medicaid services. A limited number of services are carved out of the capitated arrangement. Also see Benefits.

Credentialing - The process of obtaining, verifying, and evaluating information regarding applicable licensure, accreditation, certification, educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.

Crisis Service - a DMHA defined service that is available at short notice to help members resolve a mental health, substance use, and/or suicide-related emergency or to support members while it is happening. These services can range from 24/7 warm lines or crisis hotlines to mobile crisis response and stabilization teams and acute crisis stabilization centers.

Cultural Competency - The ability for the Contractor, healthcare professionals, and social support providers to demonstrate cultural competence toward members/patients with diverse values, beliefs, and feelings that allows for a process that includes consideration of the individual social, cultural, and psychological needs of patients for effective cross-cultural communication with their health care providers in order to reduce health disparities and to provide optimal care to patients regardless of their race, gender, ethnic background, native languages spoken, and religious or cultural beliefs.

Days – Calendar days unless otherwise specified.

Deductible - For health insurance, the amount a person must pay toward medical expenses before insurance plan begins paying.

Development Disability - A severe, chronic disability manifested during the developmental period of childhood that results in impaired intellectual functioning or deficiencies in essential skills.

Disenrollment – The discontinuance of a member's eligibility to receive covered services through an MCE.

Division of Aging – A Division of the Family and Social Services Administration. Supports the development of alternatives to nursing home care by coordinating and funding home and community-based services coordinated through a network of Area Agencies on Aging.

Division of Disability and Rehabilitative Services (DDRS) - A Division of the Family and Social Services Administration. Assists citizens of Indiana, regardless of the severity of the disability, in becoming employed and living in the least restrictive and most appropriate environment possible.

Division of Family Resources (DFR) - A Division of the Family and Social Services Administration. The State agency that offers help with job training, public assistance, supplemental nutrition assistance, and other services.

Division of Mental Health and Addiction (DMHA) - A Division of the Family and Social Services Administration. The DMHA assists people with mental illness or addiction who are uninsured or underinsured to receive treatment and re-integrate into their community. The Division operates

six state hospitals and partners with Indiana's Community Mental Health Centers (CMHC) to provide treatment in communities across Indiana.

Division of Supplier Diversity – A Division of the Indiana Department of Administration that acts on behalf of the State of Indiana to actively promote, monitor, and enforce the standards for certification of minority, women, and veteran business enterprises.

Drug Formulary - List of drugs that includes therapeutic classes for both generic and brand-name medications. Within the formulary, a drug or dosage form may be designated as “preferred” or “non-preferred.” Preferred drugs generally require minimal or no prior authorization; non-preferred drugs require prior authorization and may also require periodic regimen review or specific billing requirements.

Dual Eligible Member - A member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and a Non QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

Durable medical equipment (DME) - Equipment that is necessary for ongoing medical issues. Durable medical equipment includes purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicaid (see also: 42 CFR § 414.202).

Earned Income - Earned income may include wages, tips, salaries, or net earnings from self-employment. It may also include other compensation received from performing work activity. Earned Income is often used in determining a person's eligibility for Medicaid and other social services available through the State.

Electronic Visit Verification (EVV) - A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

Eligibility Determination - The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.

Eligible member - Person certified by the State as eligible for medical assistance.

Eligible providers - Person, organization, or institution approved by the State as eligible for participation in Medicaid.

Emergency Medical Condition - Per 42 CFR § 438.114, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part.

Emergency Medical Transportation - Per 836 IAC 1-1-1, emergency medical transportation means the transportation of emergency patients by ambulance and the administration of basic life support to emergency patients before or during such transportation.

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Emergency Room Care - Includes care given for a medical emergency when a member believes that their health is in serious danger and every second counts (see also: 42 CFR § 405.440).

Emergency Services - Per 405 IAC 5-2-9, emergency services are defined as a service provided to a member after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Encounter - A record of a health care-related service rendered by a provider or providers to a member who is enrolled with a Contractor on the date of service.

Enrollee - A Medicaid recipient who is currently enrolled with a Contractor. [42 CFR 438.2]

Enrollee encounter data - The information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between the State and a Contractor that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818. [42 CFR 438.2]

Enrollment - The process by which an enrollee becomes a member of the Contractor.

Enrollment broker - An individual or entity that performs choice counseling or enrollment activities, or both. [42 CFR 438.810(a)]

Evidence-Based Practice – An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of health care professionals; and the unique needs, concerns and preferences of the individual receiving services.

Excluded Services - Defined by the State as services that are not covered under Indiana Medicaid (see also: 405 IAC 5-29-1).

External Quality Review - As used in CFR part 438 subpart E, the analysis and evaluation by an external quality review organization (EQRO), of aggregated information on quality, timeliness, and access to the health care services that a Contractor (described in 42 CFR 438.310(c)(2)), or their contractors furnish to Medicaid beneficiaries. [42 CFR 438.320]

External Quality Review Organization (EQRO) - As used in CFR part 438 subpart E, an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other external quality review-related activities as set forth in 42 CFR 438.358.

Family and Social Services Administration (FSSA) - Indiana Family and Social Services Administration is a health care and social service funding agency with eight care divisions established by Indiana to consolidate and better integrate the delivery of human services by state government. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy and Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.

Family or Family Member - A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may encompass family of choice for adult members, which includes informal supports.

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Federal Financial Participation (FFP) - Refers to the contribution that the Federal government makes to the Title XIX and Title XXI program, as defined in 42 CFR 400.203.

Federal Poverty Level (FPL) - Individual and family income guidelines set by the federal government for the administration of social service benefits. The state-specific guidelines are adjusted for the cost of living in each state. Financial eligibility for social service programs is often based on a percentage of the FPL.

Fee-for-Service (FFS) – A method of making payment for health services based on a fee schedule that payment for defined services. Also, Indiana Medicaid program for members not enrolled with a Contractor.

Fiscal Agent - A Contractor that processes or pays vendor claims on behalf of the Medicaid agency [42 CFR 455.101].

FQHC – Federally Qualified Health Center.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (see 42 CFR 455.2).

Freedom of Choice - A state must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.

Grievance – A complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

A grievance is a complaint about the way a member's health plan is giving care. For example, a member may file a grievance if the member has a problem calling the plan or if the member is unhappy with the way a staff person at the plan has behaved toward them. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see appeal). See 42 C.F.R. §438.400(b).

Grievance and Appeal System - The processes the Contractor implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them. [42 CFR 438.400(b)]

Habilitation Services and Devices - Per 45 CFR § 156.115(a)(5), habilitative services and devices include health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples may include therapy for a child who is not walking or talking at the expected age. These services may also include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home and Community-Based Services (HCBS) – Services that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. An HCBS listing and definitions of services can be found in the HCBS Waiver Provider Manual posted on the FSSA Medicaid HCBS webpage https://www.in.gov/fssa/da/medicaid-hcbs/.

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Health Care Professional - A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist, licensed professional counselor, and licensed mental health counselor (LMHC).

Healthcare Effectiveness Data and Information Set (HEDIS) – Widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance.

Health Care Services - As used in CFR part 438 subpart E, all Medicaid services provided by an MCE, PIHP, or PAHP under contract with the state Medicaid agency in any setting, including but not limited to medical care, and behavioral health care. [42 CFR 438.320]

Health Equity - Ensuring that everyone has the chance to be as healthy as possible considering factors outside of a person's control that can prevent them from achieving their best health.

Healthy Indiana Plan - Indiana Medicaid health-insurance program for Hoosiers ages 19 to 64 who meet specific income levels.

Health Insurance - Per 45 CFR § 144.103, health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

High-Risk Member - An Indiana Medicaid member who is enrolled with Aged and Disabled (A&D) Waiver services.

HIPAA - Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164.

HIPAA Rules - The rules adopted by and promulgated by the US Department of Health and Human Services ("HHS") under HIPAA and other relevant federal laws currently in force or subsequently made, such as the Health Information Technology for Economic and Clinical Heath Act ("HITECH"), as enumerated under 45 CFR Parts 160, 162, and 164, including without limitation any and all additional or modified regulations thereof.

HITECH - Health Information Technology for Economic and Clinical Health Act, Pub.L.111-5, Div. A, Title XIII, § 13001(a), Feb. 17, 2009, 123 Stat. 226.

Home and Community-Based Services (HCBS) – Services that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. An HCBS listing and definitions of services can be found in the HCBS Waiver Provider Manual posted on the FSSA Medicaid HCBS webpage https://www.in.gov/fssa/da/medicaid-hcbs/.

Home Health Care – Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services (see also: 42 CFR § 440.70).

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Home Health Services - Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70 when provided to a member at his place of residence and on his or her physician's orders, or beginning March 1, 2020, ordered by the member's nurse practitioner, physician assistant, or clinical nurse specialist, as a part of the plan of care and is reviewed by the practitioner annually as part of a written plan of care [42 CFR 440.70].

Home Medical Equipment (HME) - Indiana Code IC 25-26-21-2 defines home medical equipment as equipment that is prescribed by a healthcare provider; sustains, restores, or supplants a vital bodily function; and is technologically sophisticated and requires individualized adjustment or regular maintenance.

Hoosier Care Connect – Indiana's health care program for individuals who are aged 65 years and older, blind, or disabled and who are also not eligible for Medicare.

Hoosier Healthwise - Indiana's health care program for children, low-income families, and pregnant women. Different benefit packages are available to the various populations eligible for Hoosier Healthwise: Package A (Standard) and Package C (CHIP).

HoosierRx - A qualified State Pharmaceutical Assistance Program. For more information, go to: https://www.in.gov/medicaid/members/194.htm.

Hospice Care - A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Hospital Insurance (see also: 42 CFR § 418.3)

Hospitalization - Per 40 CFR § 159.153, hospitalization means admission for treatment to a hospital, clinic, or other health care facility. Treatment as an out-patient is not considered to be hospitalization.

Incurred But Not Reported (IBNR) - The liability for services rendered for which claims have not been received by the Contractor.

Indian or American Indian - Any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12.

Indiana Housing & Community Development Authority – Indiana statewide housing agency that provides housing opportunities, promotes self-sufficiency, and strengthens communities.

Indiana State Department of Health (IDOH) - The State agency responsible for promotion of health and for providing guidance on public health issues. For more information go to https://www.in.gov/health/.

Indian Health Care Provider - A health care program operated by the IHS or by an I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). [42 CFR 438.14(a)]

Indian Health Service (IHS) - The federal agency charged with administering the health programs for federally recognized American Indians.

Information Systems - The component of the Contractor's organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).

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In Lieu of Services - Services or settings used in place of services and settings covered under the state plan. In Lieu of Services must be medically appropriate and cost effective as determined by the State. [42 CFR §438.3(e)(2)(iii)]

In-Network Provider - Any provider that is directly or indirectly employed by or has a provider agreement with the Contractor or subcontractor to the Contractor pursuant to the Contract between the Contractor and the State of Indiana.

Inquiry - A concern, issue or question that is expressed orally or in writing by a member.

Institution For Mental Disease (IMD) - A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance abuse disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases [42 CFR 435.1010].

Intervention – An action or ministration that is intended to produce an effect or that is intended to alter the course of a pathologic process.

Law – Statutes, codes, rules, regulations, and/or court rulings.

Level-of-Care (LOC) - A level of care determination is the outcome of the measure of an individual's care needs. This includes a determination of nursing home or institutional placement level of care need of an individual.

Lien - A legal claim that a person holds on another's property as a security for an indebtedness or charge.

Line of Business - Refers to one of the Indiana Medicaid Programs.

Limited English Proficiency (LEP) - Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may have LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. [42 CFR 438.10].

Long-Term Care Program - A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

Managed care – An arrangement whereby a single provider or organization oversees the overall care of a patient to ensure cost-efficient quality health care to its members.

Managed Care Entity (MCE) - Organization contracted with the state of Indiana for this contract that meets all applicable requirements of Medicaid managed care organizations under Sections 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438, and IC 12-15 as may be amended.

Managed Care Program - A managed care delivery system operated by a State as authorized under section 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act [42 CFR 438.2].

Mandated or required services - Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive

service package.) Mandated services include the following: hospital, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinics, certain nurse practitioners, federally qualified health centers, renal dialysis services, EPSDT (under age 21), and medical transportation.

Mandatory Report State – Indiana mandatory reporting law that establishes a legal, enforceable duty for those who have contact with vulnerable populations to report suspected neglect, battery or exploitation of an endangered adult to an APS unit or law enforcement. All reports are secured and kept confidential.

Marketing – Any communication or activity from the Contractor to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that Contractor's Medicaid product, or either to not enroll in or to disenroll from another Contractor's Medicaid product.

Marketing Materials - Materials that (1) are produced in any medium, by or on behalf of a Contractor; and (2) can reasonably be interpreted as intended to market the Contractor to potential enrollees. [42 CFR 438.104(a)]

MCE Reporting Manual – Office of Medical Policy and Planning (OMPP) instructions and specifications for managed care entities (MCEs) to submit the reports that comprise the Contractor's Reporting.

Medicaid - A Federal/State program authorized by Title XIX of the Social Security Act, as amended.

Medicaid Buy-In - This is an optional Medicaid program that allows individuals with a disability who work to retain Medicaid coverage. Individuals may pay a premium on a sliding fee scale based on their income. In Indiana, this program is called M.E.D. Works.

Medicaid-Covered Service - A service provided or authorized by a Medicaid provider for a Medicaid enrollee for which payment is available under the Medicaid program. A list of covered services is referenced in IC 12-15-5-1.

Medicaid Managed Care Regulations - The Federal law mandating, in part, that states ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated pursuant to the Balanced Budget Act (BBA) of 1997.

Medicaid-Medicare eligible – Also called Dual Eligible - Member who is eligible for benefits under both Medicaid and Medicare; also called dually eligible. Members in this category are bought-in for Part B coverage of the Medicare Program by the Medicaid Program.

Medicaid Rehabilitation Option (MRO) - Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.

Medical Expenses – Amounts paid to providers for the provision of covered physical health, behavioral health, and/or long-term care or other covered services to members.

Medical Necessity - The evaluation of health care services to determine if they are medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency, and duration of treatment.

Medically Necessary - Services or supplies that are proper and needed for the diagnosis or treatment of the member's medical condition, are provided for the diagnosis, direct care, and

treatment of the member's medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the member or the member's doctor. Medically necessary services include covered services that are required for the care or well-being of the patient and are provided in accordance with generally accepted standards of medical or professional practice to prevent disease, disability or other adverse conditions or their progression, or to prolong life. See also: 42 CFR § 438.210(a)(5).

Medically Needy - Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan but are insufficient to meet their costs of health and medical services.

Medical Records – All communications related to a patient's physical, mental health or long-term care condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Records do not include materials that are prepared in connection with utilization review, peer review, or quality assurance activities.

Medicare-The federal medical assistance program as defined under 42 USC §1395 et. seq. Act for people over the age of 65, for persons eligible for Social Security disability payments, and for certain workers or their dependents who require kidney dialysis or transplantation.

Medicare Advantage (MA) - The managed care program established for beneficiaries of Medicare Part A and enrolled under Part B, pursuant to the Medicare Modernization Act of 2003.

Medicare Advantage Plan (MA Plan) - Health benefits coverage offered under a policy or contract by an MA organization, that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the Service Area of the MA plan (or in individual segments of a Service Area [42 CFR §§422.2 and 422.304(b)(2))]

Medicare Advantage Special Needs Plan (MA SNP) – A Medicare Advantage Plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs Enrollees and provides Part D benefits under 42 CFR Part 423 to all Enrollees; and has been designated by CMS as meeting the requirements of a MA SNP as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population. [42 CFR §§422.2 and 422.4(a)(1)(iv)]

Medicare Prescription Drug Program (Part D Drug Benefit) - The prescription drug benefit for Medicare beneficiaries. [42 CFR Part 423]

M.E.D. Works - An Indiana program to provide Medicaid coverage to working individuals with disabilities who otherwise would lose or be ineligible for Medicaid coverage. It has separate eligibility requirements and a recipient premium structure based on a sliding fee scale for those individuals with disabilities who work.

Member - An eligible individual who is enrolled in Indiana Medicaid. Also referred to as enrollee, Title XIX Member or Medicaid Member.

Member Months – The number of months an enrollee or a group of enrollees is covered by Medicaid over a specified time period, such as a year. [42 CFR 428.8(b)]

Mental Health Services – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

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MLR – Medical Loss Ratio as defined in accordance with 42 CFR 438.8.

National Committee for Quality Assurance (NCQA) – An independent 501c nonprofit organization that works with policymakers, employers, doctors, patients and health plans to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

National Provider Identifier (NPI) - The ten (10) digit number issued by CMS which is the standard unique identifier for health care Providers in standard transactions.

Network - A list of the doctors, other health care providers, and hospitals that a Contractor contracts with directly, or employs through a subcontractor, to provide medical care to its members. These providers are called "network providers" or "in-network providers." A provider that isn't contracted with the Contractor is called an "out-of-network provider."

Network Provider - Any provider, group of providers, or entity that has a network provider agreement with the MCO or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render Covered Services as a result of this Contract. A network provider is not a subcontractor by virtue of the network provider agreement. [42 CFR §438.2]

Non-Participating Provider - A provider who does not accept assignment on all Medicaid claims.

OMPP – Office of Medical Policy and Planning under the Indiana Family and Social Services Administration (FSSA).

Options Counseling – Options Counseling, is an Area Agency on Aging function, as defined by the Older Americans Act, and will be a service AAAs continue to provide (e.g., counseling pertaining to Title III services, Social Services Block Grant, OAA, etc.) in their role as Aged and Disabled Resource Centers. MCEs do not conduct Options Counseling.

Other Full-Benefit Dually Eligible (FBDE) – A federal category of Medicaid where the member is eligible for Medicaid either categorically or through optional coverage groups but is not enrolled for QMB or SLMB. An FBDE is eligible for Medicaid payment of Medicare premiums, deductibles, co-insurance and co-pays (except for Part D).

Out-of-Network Provider – Any provider that is not directly or indirectly employed by or does not have a provider agreement with the Contractor or any of its subcontractors pursuant to the Contract between the Contractor and the State of Indiana.

Outpatient Hospital Services: Per 42 CFR § 440.20, outpatient hospital services mean preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

(1) are furnished to outpatients;
(2) are furnished by or under the direction of a physician or dentist; and
(3) are furnished by an institution that:
    (i) is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
    (ii) meets the requirements for participation in Medicare as a hospital; and
(4) may be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State.

Participating Provider - Per IC 27-13-1-24, a participating provider means a provider who, under an express or implied contract with: (1) the health maintenance organization; or (2) a contractor of

the health maintenance organization or any subcontractor of a contractor of the health maintenance organization; has agreed to provide health care services to enrollees with an expectation of directly or indirectly receiving payment, other than copayment or deductible, from the health maintenance organization.

Party in Interest - As defined in §1318(b) of the Public Health Service Act.

PASRR – Preadmission Screening and Resident Review – a set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.

Pass-through Payments – As defined at 42 CFR 438.6.

Patient Liability – The amount of an enrollee's income, as determined by the State, to be collected each month to help pay for the enrollee's nursing facility stay.

Per diem – Daily rate charged by institutional providers.

Performance Improvement Project (PIP) - A plan to remediate an identified program deficiency in response to a sanction or action by the State involving a process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

Performance Standards - Standardized measures designed to assist in evaluating, comparing, and improving the performance of the Contractors.

Person-centered planning process – See requirements as defined in 42 CFR 441.301(c)(1). Person-centered planning is a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community. Most important, it is a process that is directed by the person who receives the support.

Pharmacy Benefits Manager (PBM) – An entity responsible for the provision and administration of pharmacy services.

Physician Services - Include services provided by an individual licensed under State law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included (see also: 42 CFR § 414.2).

Plan - Per 42 CFR § 400.203, State Plan, or Plan, refers to the comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the Social Security Act, to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

Plan of care (POC) - A formal plan developed to address the specific needs of an individual. It links clients with needed services.

Population Health - The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Potential Enrollee - A Medicaid-eligible recipient who is not yet enrolled with a Contractor. [42 CFR 438.10(a)].

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Pre-admission screening (PAS) - A nursing home and community-based services program implemented that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.

Preauthorization - Per 42 CFR § 419.81, preauthorization (or prior authorization) means the process through which a request for provisional affirmation of coverage is submitted to CMS or its contractors for review before the service is provided to the beneficiary and before the claim is submitted for processing. Through this process, the Contractor authorizes, in advance, the delivery of covered services based on factors, including but not limited to, medical necessity, cost effectiveness, in compliance with any applicable contract or policy provisions.

Premium - Per 42 CFR § 447.51, premium means any enrollment fee, premium, or other similar charge.

Prescription Drug - Per 21 § CFR 203.3(y), prescription drug means any drug (including any biological product, except for blood and blood components intended for transfusion or biological products that are also medical devices) required by Federal law (including Federal regulation) to be dispensed only by a prescription, including finished dosage forms and bulk drug substances subject to section 503(b) of the Social Security Act.

Prescription Drug Coverage - Per 42 CFR § 423.100, prescription drug coverage means coverage of Part D drugs that is either standard prescription drug coverage or basic alternative coverage.

Prevalent - A non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient. [42 CFR 438.10(a)]

Primary Care - All health care services, and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes the service. [42 CFR 438.2].

Primary Care Doctor – See Primary Medical Provider.

Primary Care Provider (PCP) – See Primary Medical Provider.

Primary Medical Provider (PMP) – Also known as a Primary Care Provider (PCP) or primary care doctor, is a primary care physician or other licensed health practitioner practicing in accordance with State law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. At a minimum, providers allowed to serve as PMPs must include physicians, physician assistants, and advanced practice registered nurses.

Privacy Rule – Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164.

Protected Health Information (PHI) – Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium (and collectively defined in IC 4-1-6-1 and IC 4-1-11-3, "PII") on the State's behalf pursuant to and consistent with the services performed by the Contractor under the Contract with Indiana.

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Provider – Per 42 CFR 438.2, a provider is defined as any individual, organization, or institution (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, ambulatory surgical centers, outpatient clinics, or other entity that is licensed or otherwise authorized to provide any of the covered services in the State in which they are furnished) that provides medical services to beneficiaries covered under this Contract. Provider does not include consumer-directed workers (refer to Consumer-Directed Worker); nor does provider include the FEA (refer to Fiscal Employer Agent).

Provider Agreement – An agreement between the Contractor and a provider or between the Contractor's subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to the Contractor's members.

Prudent Layperson - For purposes of determining whether an emergency medical condition exists, an individual without medical training who relies on the experience, knowledge, and judgment of a reasonable individual to make a decision regarding whether or not the absence of immediate medical attention will result in 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of a bodily part or organ.

Qualified Disabled Working Individual (QDWI) - A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.

Qualified Medicare Beneficiary-Also - The QMB-Also program is for people who receive Part A Medicare and whose income is below 100 percent of poverty. This program pays Medicare co-payments and co-insurance amounts for medical services covered by Medicare, including the co-payments for Medicare-approved skilled nursing home care. It also pays the Medicare Part B premiums for eligible clients.

Qualified Medicare Beneficiary Dual Eligible Member (QMB DUAL) - A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits for QMB members include payment of Medicare premiums, coinsurance, and deductibles only.

Qualified Medicare Beneficiary (QMB) Only - A federal category of Medicaid eligibility where the member's benefits are limited to payment of the member's Medicare Part A (if member is not entitled to free Part A) and Part B premiums as well as deductibles and co-insurance or copayment for Medicare-covered services only.

Qualified Medicare Beneficiary Plus (QMB+) – A federal category of Medicaid eligibility where the member's benefits include payment of the member's Medicare premiums, deductibles, and co-insurance or copayment on Medicare-covered services in addition to Traditional Medicaid benefits.

Qualifying Individual (QI) – A federal category of Medicaid eligibility where the member's benefit includes payment of the member's Medicare Part B premium. The Eligibility Verification System (EVS) identifies this coverage as Qualified Individual.

Quality Improvement Project - A planned strategy for program improvement and is incorporated into the Contractor's Quality Management and Improvement Report.

EXHIBIT 5B

CONTRACT DEFINITIONS

Quality Management - The evaluation and assessment of member care and services to ensure adherence to standards of care and appropriateness of services; can be assessed at a member, provider, or population level.

Recipient Identification Number (RID) - The unique number assigned to a member who is eligible for Medicaid services. May also be Member Identification Number.

Recoupment - The process by which a Contractor, the State of Indiana, or the Federal government, or any of their Bureaus, Agencies or Contractors recover Title XIX monies paid to an MCO, provider or enrollee.

Referral - A verbal, written, telephonic, electronic, or in-person request for health services.

Rehabilitative Services and Devices - Include health care services and devices to help a member recover from an illness or injury. These services may be given by nurses and physical, occupational, and speech therapists. Examples may include working with a physical therapist to help a member walk and with an occupational therapist to help a member get dressed.

Reinsurance - A stop-loss program to be purchased by the Contractor from a commercial reinsurer for the partial reimbursement of covered medical services to transfer risk from the Contractor to the reinsurer. Reportable Unusual Occurrence – An incident of suspected abuse, neglect, or exploitation or other situations that place at risk an adult or child receiving HCBS.

Reportable Unusual Occurrence – An incident of suspected abuse, neglect, or exploitation or other situations that place at risk an adult or child receiving HCBS.

Related Party - A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the Contractor and their immediate families, subcontractors, wholly owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

Religious Grounds - Moral guidance on various aspects of health care delivery based on a religious organization's theological and moral teachings.

Reportable Unusual Occurrence – An incident of suspected abuse, neglect, or exploitation or other situations that place at risk an adult or child receiving HCBS.

Request For Proposal (RFP) - A document which describes the scope of services required and which instructs a prospective offeror how to prepare a response (Proposal).

RHC – Rural Health Clinic.

Risk Contract - Contract between the State and MCE Contractor, under which the Contractor: 1. Assumes risk for the cost of the services covered under the Contract, and 2. Incurs loss if the cost of furnishing the services exceeds the payments under the Contract. [42 CFR 438.2]

Risk Corridor - A risk sharing mechanism in which states and the Contractor may share in profits and losses under the contract outside of a predetermined threshold amount. [42 CFR 438.6]

Room and Board - The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when an individual lives in an institutional setting (e.g., NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an Alternative HCBS Setting or an apartment like setting that may provide meals.

EXHIBIT 5B

CONTRACT DEFINITIONS

Service Authorization - A managed care enrollee's request for the provision of a service. [42 CFR431.201]

Service Gap – A delay in initiating any long-term care service and/or a disruption of a scheduled, ongoing HCBS that was not initiated by a member, including late and missed visits.

Shall – Indicates a mandatory requirement or a condition to be met. Note: The term 'Shall' is used interchangeably in this Contract with the term 'Must'.

Skilled Nursing Care - A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse) (see also: 42 CFR § 409.44(b)).

Special Health Care Needs (SHCN) - Serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

Specialist - A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems. A specialist is a board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

Specialty Services – Includes any required Essential Hospital Services, Centers of Excellence, and specialty physician services.

Specified Low-Income Medicare Beneficiary (SLMB) Only - The member's benefits are limited to payment of the member's Medicare Part B premium only.

Specified Low-Income Medicare Beneficiary Plus (SLMB+) - The member's benefits include payment of the member's Medicare Part B premium in addition to Traditional Medicaid benefits throughout each month of eligibility, including deductibles, co-insurance and co-pays (except for Part D).

SSA – Social Security Administration.

SSI – Supplemental Security Income.

State – The State of Indiana, including, but not limited to, any entity or agency of the state.

State Fair Hearing (SFH) Process - In accordance with 42 CFR 438.400(b), the State process set forth in subpart E of part 431 chapter IV, title 42 which allows members the opportunity to appeal the Contractor's decisions to the State. Refer to 405 IAC 1.1 for the appeal procedures for applicants and recipients of Medicaid.

State Fiscal Year – The Indiana budget year-State fiscal year: July 1 through June 30.

Subcontract – An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor, specifically related to securing or fulfilling the Contractor's obligations under the terms of the Contract with Indiana when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by the Contract between Indiana and the Contractor.

EXHIBIT 5B

CONTRACT DEFINITIONS

Subcontractor – Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations under the terms of the contract between Indiana and the Contractor.

Subsidiary - An entity owned or controlled by the Contractor.

Substance Use Disorder (SUD) Services – The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral or supervision of individuals who are using or have abused substances.

Supplemental Security Income (SSI) and SSI Related Groups - Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or have a disability and have household income levels at or below 100 percent of the FPL.

Temporary Assistance for Needy Families (TANF) - Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act.

Third Party Liability (TPL) - A member's medical payment resources, other than Medicaid, available for paying all or part of the cost of services for the enrollee.

Treatment - A procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue.

Unearned Income - Disability payments or other funds that an individual receives without any physical or mental work performed. Examples of unearned income may be Social Security Disability Insurance Benefits, income from a trust, investments, support payments, or funds received from any other source other than work.

Urgent Care - Per 42 CFR § 405.400, urgent care services means services furnished to an individual who requires services to be furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition.

USC – United States Code.

Unusual Occurrence - Is defined in 455 IAC 2-4-27. It means an incident of suspected abuse, neglect, or exploitation or other situations that place at risk an adult or child receiving HCBS.

Waiver Services LOC - Level of Care determined through an assessment submitted by the Contractor to an LOC vendor for determination of eligibility for HCBS waiver services.

Waste - is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Wellness - An approach to health care that emphasizes not merely the absence of disease or infirmity but the pursuit of optimum health. It is an active process of helping members become aware of and make choices that will help them to achieve a healthy and more fulfilling life. Wellness includes preventing illness, prolonging life, and improving quality of life, as opposed to focusing solely on treating diseases.

Withhold Arrangement - Payment mechanism under which a portion of a capitation rate is withheld from a Contractor and a portion of or all the withheld amount will be paid to the Contractor for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. [42 CFR 438.6]

EXHIBIT 6B

CAPITATION RATES – HEALTHY INDIANA PLAN

Actuarial Certification:

The actuarial certification for each Contract year is incorporated in this Contract by reference. Actuarial certifications or amendments to certifications that have been signed by contracted entities and approved by CMS will be considered binding on all parties. As a matter of convenience, rates and other information from the certification are reproduced in this section of the Contract, but the certifications generally contain additional detail that should also be considered a part of this Contract.

Note on Rates and Rate Adjustment:

To the extent covered benefits or State-directed fee schedules are adjusted, capitation rates will be subject to revision in order to reflect the required program change. Future capitation rates will also be adjusted each year to reflect new base year data.

From time to time the State may adjust other fee schedules related to covered services for which reimbursement is not State-directed, as defined in 42 CFR 438.6(c)(iii), under this Contract. Where reimbursement is not State-directed, the Contractor may negotiate separate and distinct reimbursement with service providers, constrained only by other Contract provisions, such as access requirements. Should the State change these other fee schedules, there will be no related capitation rate adjustment.

Note on Retroactive Acuity Adjustment:
The Contractor's 2023, 2024, and 2025 capitation rates shall be adjusted using a non-cost neutral retroactive acuity adjustment. This replaces the cost neutral risk adjustment process that may be utilized in other years of the contract. The State's intent is to mitigate uncertainty regarding changes in member morbidity levels due to the COVID-19 pandemic, maintenance of effort, and return to normal operations.

Risk scores will be developed using the Chronic Illness and Disability System and Medicaid Rx (CDPS + MRx), version 7.0, using concurrent weights, custom-developed using program experience. If found to be material, the rates may also be adjusted for duration and/or treatment reduction impacts if changes in duration and/or treatment are judged to be material based on the claims experience.

For 2023 rates – Retroactive Acuity Adjustment

For each rate group, base risk scores will be developed using aggregate experience from the capitation rate base data period from all contractors, using data from members enrolled during the base data period. For continuing contractors, initial average risk scores stratified by Contractor will be developed with data from each Contractor's members during March 2022 using experience from the 12 months prior. For all contractors, these initial risk scores will be completely replaced by the final calendar year 2023 risk scores, which will be stratified by Contractor and calculated with data from all members enrolled as of March 2023 and September 2023, using experience from the 12 months prior to each of the snapshot dates. In aggregate, final 2023 risk scores will represent the average acuity of members enrolled with each Contractor during the rating period. This calculation and adjustment will be made at the sole discretion of the State. The State reserves the right to base the acuity adjustment applied for CY 2023 on enrollment from months other than March 2023 and September 2023, if it is determined that using different months may better represent the average acuity of each Contractor's members enrolled during the full rating period.

For each set of risk scores above, claims run-out will be limited to an equal number of months in order to provide consistency between time periods. The run-out period shall be determined at the sole discretion of the State. Benefit costs developed from the rate setting base data will be

adjusted to reflect the change in morbidity from the base data year to 2022 (initial rates) and ultimately calendar year 2023 (final rates).

For 2024 rates – Retroactive Acuity Adjustment

For each rate group, base risk scores will be developed using aggregate experience from the capitation rate base data period from all contractors, using data from members enrolled during the base data period. The initial rates will contain the following temporary adjustments:

- Budget neutral adjustment: Initial average risk scores stratified by Contractor will be developed with data from each Contractor's members enrolled as of September 2022 using experience from the 12 months prior to the snapshot date. This budget neutral adjustment will reflect relative differences in member acuity by contractor.

- Temporary, prospective acuity adjustment factor. This factor is intended to project average acuity levels during calendar year 2024, including consideration for the impact of member redeterminations. This factor will be the same for all contractors.

These initial budget neutral risk scores and the additional prospective acuity adjustment factor will be completely replaced by the final calendar year 2024 risk scores, which will be stratified by Contractor and calculated with data from all members enrolled as of March 2024 and September 2024, using experience from the 12 months prior to each of the snapshot dates. In aggregate, final 2024 risk scores will represent the average acuity of members enrolled with each Contractor during the rating period. This calculation and adjustment will be made at the sole discretion of the State. The State reserves the right to base the acuity adjustment applied for CY 2024 on enrollment from months other than March 2024 and September 2024, if it is determined that using different months may better represent the average acuity of each Contractor's members enrolled during the full rating period.

For each set of risk scores above, claims run-out will be limited to an equal number of months in order to provide consistency between time periods. The run-out period shall be determined at the sole discretion of the State. Benefit costs developed from the rate setting base data will be adjusted to reflect the change in morbidity from the base data year to 2022 with an additional adjustment for expected, future acuity changes (initial rates) and then ultimately calendar year 2024 (final rates).

For 2025 rates – Retroactive Acuity Adjustment

For each rate group, base risk scores will be developed using aggregate experience from the capitation rate base data period from all contractors, using data from members enrolled during the base data period. For continuing contractors, initial average risk scores stratified by Contractor will be developed with data from each Contractor's members during December 2023 using experience from the 12 months prior. For all contractors, these initial risk scores will be completely replaced by the final calendar year 2025 risk scores, which will be stratified by Contractor and calculated with data from all members enrolled as of June 2025, using experience from the 12 months prior to the snapshot date. In aggregate, final 2025 risk scores will represent the average acuity of members enrolled with each Contractor during the rating period. This calculation and adjustment will be made at the sole discretion of the State. The State reserves the right to base the acuity adjustment applied for CY 2025 on enrollment from months other than June 2025, if it is determined that using different months may better represent the average acuity of each Contractor's members enrolled during the full rating period.

For each set of risk scores above, claims run-out will be limited to an equal number of months in order to provide consistency between time periods. The run-out period shall be determined at the sole discretion of the State. Benefit costs developed from the rate setting base data will be

adjusted to reflect the change in morbidity from the base data year to 2023 (initial rates) and ultimately calendar year 2025 (final rates).

Note on Incentive Payment Withholding:

The capitation rates listed in this exhibit do not reflect any withhold amounts. FSSA will withhold a portion of the approved capitation payments from the Contractor on the following schedule:

- Year 1, 2023 – one point eight zero percent (1.80%)
- Year 2, 2024 – one point eight five percent (1.85%)
- Year 3, 2025 – one point nine zero percent (1.90%)

The percentage withholding will increase in future Contract years, as listed in Exhibit 2.B, the Contract Compliance and Pay for Outcomes Contract Exhibit. Withhold payments will be calculated as set forth in Section B of Exhibit 2.B, and the Contractor may be eligible to receive some or all of the withheld funds based on Contractor's performance in the areas outlined therein.

Note on Risk Corridor:

For calendar years 2023, 2024, and 2025 the State is implementing a two-sided risk corridor around the benefit cost portion of per member per month capitation rates. This risk corridor calculation shall be calculated separately for each Contractor, by program and year. The Contractor shall retain at most two percent (2%) of the overall gains or losses. The Contractor is at full risk for the first one point five percent (1.5%) of gains or losses. For gains and losses over one point five percent (1.5%) and up to two point five percent (2.5%) the State and Contractor shall share the risk evenly. Gains or losses above the first two point five percent (2.5%) revert to the State.

The targeted benefit cost shall be calculated by the State for each Contractor by program and year. The targeted benefit cost shall be calculated according to the method described in the actuarial certification for each applicable Contract year incorporated in this Contract by reference.

The actual benefit cost incurred by the Contractor shall include all regular medical expenditures in the encounter data. For sub-contracted services, only the amount paid to providers may be included; sub-contracted administrative costs are excluded. Expenditures will be evaluated net of selected costs, including third-party liability, pharmacy supplemental rebates, and net reinsurance recoveries. Benefit costs do not include non-encounterable data.

A reconciliation, to be calculated and finalized at the sole discretion of the State, will compare the actual per member per month benefit cost incurred by the Contractor to the targeted benefit cost, and result in a per member per month amount. The dollar value of the remittance is the product of the per member per month amount and the Contractor's calendar year member months.

The State shall perform an interim reconciliation of the calendar year 2023 risk corridor using claim experience with dates of service from January through June of calendar year 2023, allowing for runout through September 30, 2023. A full reconciliation of calendar year 2023 dates of service will occur using claim experience with runout through September 30, 2024.

The calendar years 2024 and 2025 risk corridor reconciliation schedules will mirror the calendar year 2023 risk corridor reconciliation schedule. The calendar year 2024 risk corridor will use the same methodology for determining the target benefit cost but use the calendar year 2024 capitation rates as a basis. The calendar year 2025 risk corridor will use the same methodology for determining the target benefit cost but use the calendar year 2025 capitation rates as a basis. The calendar years 2024 and 2025 risk corridors will have the same tiered structure and parameters as the calendar year 2023 risk corridor. Actual benefit cost will be defined in the same

manner. Timing for the reconciliation will also be similar, with dates advanced one year for each new rate year.

Note on Calendar Year 2023 Capitation Rates:

No further adjustments to the Calendar Year 2023 capitation rates are anticipated.

2023 Healthy Indiana Plan Capitation Rates
Effective January 1, 2023 - May 31, 2023

All rates before adjustment for 1.80% withhold and after risk adjustment.

Non-Expansion Healthy Indiana Plan State Plan Members

Male – Basic	
18 – 24	$ 162.55
25 – 34	256.58
35 - 44	318.73
45 and Over	532.38

Female – Basic	
18 – 24	$ 201.49
25 - 34	284.81
35 - 44	450.46
45 and Over	544.46

Male – Plus	
18 - 24	$ 268.00
25 - 34	233.50
35 - 44	349.89
45 and Over	521.10

Female – Plus	
18 - 24	$ 192.78
25 - 34	306.04
35 - 44	499.59
45 and Over	691.78

Expansion Healthy Indiana Plan Non-State Plan and State Plan Members

Male – Basic	
18 - 24	$ 230.52
25 - 34	611.64
35 - 44	805.51
45 - 54	1,239.01
55 - 64+	1,547.47

Female – Basic	
18 - 24	$ 291.57
25 - 34	565.29
35 - 44	824.42
45 - 54	1,052.18
55 - 64+	1,323.34

Male – Plus	
18 - 24	$ 196.05
25 - 34	355.63
35 - 44	507.99
45 - 54	755.18
55 – 64+	961.87

Female – Plus	
18 - 24	$ 226.44
25 - 34	366.02
35 - 44	549.18
45 - 54	782.80
55 - 64+	865.76

Other HIP Groups

Pregnant Females - Composite	$ 395.51
Maternity Case Rate - Composite	10,561.02

EXHIBIT 6B

CAPITATION RATES – HEALTHY INDIANA PLAN

2023 Healthy Indiana Plan Capitation Rates
Effective June 1, 2023 - December 31, 2023

All rates before adjustment for 1.80% withhold and after risk adjustment.

Non-Expansion Healthy Indiana Plan State Plan Members

Male – Basic	
18 – 24	$ 156.43
25 – 34	246.67
35 - 44	308.85
45 and Over	515.08

Female – Basic	
18 – 24	$ 203.13
25 - 34	288.41
35 - 44	457.44
45 and Over	554.27

Male – Plus	
18 - 24	$ 285.29
25 - 34	248.33
35 - 44	373.38
45 and Over	555.01

Female – Plus	
18 - 24	$ 205.47
25 - 34	326.32
35 - 44	533.10
45 and Over	737.99

Expansion Healthy Indiana Plan Non-State Plan and State Plan Members

Male – Basic	
18 - 24	$ 255.50
25 - 34	667.92
35 - 44	876.33
45 - 54	1,344.98
55 - 64+	1,672.67

Female – Basic	
18 - 24	$ 330.48
25 - 34	633.96
35 - 44	921.24
45 - 54	1,174.58
55 - 64+	1,479.74

Male – Plus	
18 - 24	$ 197.29
25 - 34	358.09
35 - 44	511.36
45 - 54	760.23
55 – 64+	964.33

Female – Plus	
18 - 24	$ 231.26
25 - 34	375.03
35 - 44	562.71
45 - 54	802.98
55 - 64+	887.27

Other HIP Groups

Pregnant Females - Composite	$ 411.18
Maternity Case Rate - Composite	10,602.68

EXHIBIT 6B

CAPITATION RATES – HEALTHY INDIANA PLAN

Note on Calendar Year 2024 Capitation Rates:

The following rate adjustments are anticipated at a future time, but are not reflected in the capitation rates documented in this section:

- Adjustment to reflect updates made to the State-directed outpatient hospital fee schedule for CY 2024
- Adjustment to reflect any state-directed Hospital Assessment Fee (HAF) fee schedule changes that become effective during CY 2024
- Adjustment to reflect any State-directed PFAC fee schedules during CY 2024
- Adjustment to reflect any State-directed applied behavioral analysis (ABA) fee schedule updates that may be implemented by FSSA during CY 2024
- Adjustment to refine impacts from new professional and ancillary State-directed fee schedules that are expected to be implemented for CY 2024
- Adjustment to reflect any other changes made to State-directed fee schedules during CY 2024
- Adjustment to apply retrospective acuity adjustment based on actual 2024 risk scores

2024 Healthy Indiana Plan Capitation Rates
Effective January 1, 2024 - December 31, 2024

All rates before adjustment for 1.85% withhold and after risk adjustment.

Non-Expansion Healthy Indiana Plan State Plan Members

Male – Basic	
18 – 24	$ 170.56
25 – 34	254.97
35 - 44	384.82
45 and Over	608.84

Female – Basic	
18 – 24	$ 192.35
25 - 34	291.01
35 - 44	443.00
45 and Over	550.48

Male – Plus	
18 - 24	$ 193.37
25 - 34	251.59
35 - 44	381.21
45 and Over	595.97

Female – Plus	
18 - 24	$ 219.81
25 - 34	345.23
35 - 44	519.96
45 and Over	746.34

Expansion Healthy Indiana Plan Non-State Plan and State Plan Members

Male – Basic	
18 - 24	$ 547.96
25 - 34	744.01
35 - 44	811.37
45 - 54	1,227.63
55 - 64+	1,363.20

Female – Basic	
18 - 24	$ 392.22
25 - 34	599.80
35 - 44	845.40
45 - 54	1,065.98
55 - 64+	1,356.53

EXHIBIT 6B

CAPITATION RATES – HEALTHY INDIANA PLAN

Male – Plus	
18 - 24	$ 216.12
25 - 34	369.71
35 - 44	537.88
45 - 54	803.47
55 – 64+	1,065.12

Female – Plus	
18 - 24	$ 231.00
25 - 34	388.20
35 - 44	570.95
45 - 54	844.08
55 - 64+	909.52

Other HIP Groups

Pregnant Females - Composite	$ 501.10
Maternity Case Rate - Composite	9,538.47

EXHIBIT 6B

CAPITATION RATES – HEALTHY INDIANA PLAN

Note on Calendar Year 2025 Capitation Rates:

The following rate adjustments are anticipated at a future time, but are not reflected in the capitation rates documented in this section:

- Adjustment to reflect updates made to the State-directed outpatient hospital fee schedule for CY 2025
- Adjustment to reflect any State-directed Hospital Assessment Fee (HAF) fee schedule changes that become effective during CY 2025
- Adjustment to reflect State-directed fee schedule changes for non-HAF facilities effective CY 2025
- Adjustment to reflect any State-directed PFAC fee schedules during CY 2025
- Adjustment to refine impacts from new professional and ancillary State-directed fee schedules that are expected to be implemented for CY 2025
- Adjustment to reflect any other changes made to State-directed fee schedules during CY 2025
- Adjustment to apply retrospective acuity adjustment based on actual 2025 risk scores
- Adjustment to reflect expected changes in per member per month costs due to implementation of Indiana's Certified Community Behavioral Health Clinic Demonstration Program

2025 Healthy Indiana Plan Capitation Rates
Effective January 1, 2025 - December 31, 2025

All rates before adjustment for 1.90% withhold and after risk adjustment.

Non-Expansion Healthy Indiana Plan State Plan Members

Male – Basic	
18 – 24	$ 149.17
25 – 34	228.80
35 - 44	361.09
45 and Over	549.94

Female – Basic	
18 – 24	$ 208.87
25 - 34	326.94
35 - 44	461.24
45 and Over	630.73

Male – Plus	
18 - 24	$ 216.31
25 - 34	275.54
35 - 44	408.83
45 and Over	667.52

Female – Plus	
18 - 24	$ 243.78
25 - 34	384.54
35 - 44	574.40
45 and Over	809.48

Expansion Healthy Indiana Plan Non-State Plan and State Plan Members

Male – Basic	
18 - 24	$ 585.97
25 - 34	833.70
35 - 44	963.43
45 - 54	1,303.99
55 - 64+	1,566.02

Female – Basic	
18 - 24	$ 496.48
25 - 34	701.89
35 - 44	969.71
45 - 54	1,322.99
55 - 64+	1,519.92

EXHIBIT 6B

CAPITATION RATES – HEALTHY INDIANA PLAN

Male – Plus	
18 - 24	$ 209.17
25 - 34	359.30
35 - 44	528.95
45 - 54	775.65
55 – 64+	1,020.33

Female – Plus	
18 - 24	$ 238.33
25 - 34	403.23
35 - 44	608.19
45 - 54	881.46
55 - 64+	964.41

Other HIP Groups

Pregnant Females - Composite	$ 440.77
Maternity Case Rate - Composite	8,921.74