INDIANA HEALTH COVERAGE PROGRAMS

MANAGED CARE ENTITY POLICIES AND PROCEDURES MANUAL

Healthy Indiana Plan Policies and Procedures Manual

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4.0	Policies and Procedures as of Jan. 24, 2024 Published: Jan. 24, 2024	Updated document to align with the HIP Scope of Work Table of Contents	FSSA and Gainwell

Table of Contents

Section 1: Background

The *Healthy Indiana Plan MCE Policies and Procedures Manual* is provided to each managed care entity (MCE) contracting with the state to administer services to Healthy Indiana Plan (HIP) members. This manual provides an overview of each MCE's role in the program and the interactions and interfaces among the MCEs, the state, and other contractors.

This manual is organized into the following sections:

- *Background* outlines the Indiana Health Coverage Programs (IHCP), including the HIP program objectives and components and MCE enrollment.
- *Manage Care Entity – Contractor Requirements* includes information about eligibility requirements for an MCE, the MCE's expected role in the HIP program and staffing requirements.
- *HIP Plan Design and Member Eligibility* describes how managed care entities (MCEs) must comply with the requirements to participate in the Healthy Indiana Plan (HIP) program.
- *Billing and Collections* describes the HIP payment program and the expectations for program administration. In addition, the steps for Personal Wellness and Responsibility (POWER) Account reconciliation at redetermination are provided.
- *Personal Wellness and Responsibility (POWER) Accounts* covers the *POWER Account Reconciliation Process*, *PRF Terminations*, *PRF Rollover*, *PRF Rollover Transfers*, *PRF Voids*, and *PRF 820 Capitation Process* based on changes that occur during the benefit plan period.
- *Covered Benefits and Services* describes the services that are covered and excluded from the various programs under the managed care umbrella, which includes HIP. Information is also included about in-network versus out-of-network services and self-referral services. The pharmacy benefit is included to provide a thorough understanding of the MCE's responsibilities.
- *Member Services* details the regulations and general program expectations relating to member education and enrollment, member helpline, grievance, and member-provider communication information for HIP.
- *Provider Network Requirements* describes the requirements and processes with respect to eligible MCEs and providers, network development, enrollment processes, disenrollment processes, and reporting requirements. This section provides details about the MCE's requirements for enrollment, education, and practice standards for network providers that render services to HIP members.
- *Quality Management and Utilization Management* is a critical aspect of managed care and expectations, incentive programs, compliance, monitoring, and reporting for HIP.
- *Program Integrity* details how the MCE 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 MCE's compliance plan.
- *Information Systems* describes the functionality required and the data sharing and reporting requirements of the MCEs in reference to encounter data, third-party liability (TPL), and general financial reporting, including for HIP POWER Accounts.
- *Performance Reporting and Incentives* describes submission of performance data to the state.
- *Member Communication on Rollover and Application* lists the information that MCEs must explain to members about rollover in their communications.

In addition to these sections, Appendixes provide information about extracts, forms, POWER Account reconciliation, and so forth.

1.1 Healthy Indiana Plan

Indiana offers HIP members a comprehensive benefit package through a deductible health plan paired with a personal healthcare account called a POWER Account. This health plan is subject to a $2,500 *deductible* and includes *first-dollar* coverage for ACA-required preventive services. The preventive services benefit is designed to help eliminate barriers to obtaining preventive care.

In 2015, HIP was changed to provide healthcare coverage to all non-disabled low-income adults between the ages of 19 and 64 with household income at or below 138% federal poverty level (FPL). This change included the transition to HIP of many members who were previously enrolled in Hoosier Healthwise. This transition to HIP promoted better health outcomes for individuals, but also reduced churn between the programs, created administrative efficiencies, and provided a seamless experience for the members. In addition, the POWER Account changed from a $1,100 deductible to a $2,500 deductible while still including first-dollar coverage for preventive services. The annual and lifetime caps were also removed from the plan.

HIP has distinct benefit packages: *HIP Plus*, *HIP Basic*, *HIP State Plan Plus*, *HIP State Plan Basic*, and *HIP Maternity*.

- *HIP Plus* (MARP): *HIP Plus* is available for all members enrolled in HIP who choose to make their POWER Account contribution. Individuals in *HIP Plus* make a POWER Account contribution and do not have copayments for services. They have a copayment for nonemergent use of the emergency department (ED).
- *HIP Basic* (MARB) is the default option for members with income at or below 100% FPL, which does not take into account the 5% cost-share, who fail to make a POWER Account contribution. *HIP Basic* requires the member to make copayments at the point of service for services received from a provider, with the exception of preventive services. Individuals enrolled in *HIP Basic* are allowed to reenroll in *HIP Plus* upon their annual redetermination if they choose to begin paying their POWER Account contributions.
- *HIP State Plan Plus* (MASP): Individuals enrolled in *State Plan Plus* benefits have access to the greater benefit package available under the *State Plan*. Those in *State Plan Plus* have the same cost-sharing requirements as *HIP Plus*, they must make a POWER Account contribution, and they do not have copayments for services.
- *HIP State Plan Basic* (MASB): Individuals enrolled in *State Plan Basic* benefits have access to the greater benefit package available under the *State Plan*. Those in *State Plan Basic* have the same cost-sharing requirements as *HIP Basic* and they have the same copayments for services.
- *HIP Maternity* (MAMA): HIP members who become pregnant will be transitioned to *HIP Maternity* for their pregnancy and 12-month postpartum period. Pregnant HIP members will not have cost-sharing requirements and will have enhanced services.

All HIP members have a POWER Account. The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and is funded with state and member contributions. Employers and other third parties (for example, nonprofit organizations and family members) may also contribute some or all of the member's POWER Account contribution. 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 (for example, Flexible Spending Accounts, Health Reimbursement Accounts, and so forth) under federal law. POWER Accounts are not subject to regulation under the U.S. Tax Code as such.

HIP members are not fully eligible, or enrolled as members, until the earlier of:

- Payment of their first POWER Account contributions
- Payment of a "Fast Track" $10 prepayment (PPAC) or

- For individuals at or below 100% FPL, the expiration of the 60-day payment period. HIP-accepted members who are still in the initial 60-day payment period who have not yet paid their first POWER Account contributions are referred to as "conditionally eligible."

Section 1931 parents and caretakers will continue to be eligible for Medicaid State Plan benefits but are deemed eligible for *HIP State Plan* benefits. Individuals enrolled in State Plan benefits are subject to the same cost-sharing components as *HIP Plus* or *HIP Basic* through a POWER Account contribution or copayments. In addition to this group, low-income 19- and 20-year-old dependents are also afforded the opportunity to receive State Plan benefits.

The medically frail determination is based on *42 CFR §440.315(f)*. These individuals will be determined medically frail through the claims and pharmacy data or self-report. The claims data is applied by the MCEs through Milliman underwriting guidelines to determine whether they are medically frail. Additional information regarding the medically frail determination can be found in *POWER Account Reconciliation*.

Throughout this manual, the *member* may also be referred to as an *enrollee* (and may be referred to as *recipient* by other social service agencies). The following outlines the definitions for *enrollee* and *potential enrollee*, as defined in the federal regulations. For the purpose of this manual, enrollees are in the HIP program:

- *Enrollee* is a Medicaid member who is currently enrolled in an MCE.
- *Potential enrollee* is a Medicaid member who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an enrollee of a specific MCE.

The healthcare industry, and managed care in particular, is constantly changing to meet the demands of its patients, providers, and payers. HIP is subject to many of these changes. HIP is a fluid program striving to meet the needs of its many constituents. The state provides many forums – formal and informal – to address the concerns of HIP participants and refine policies to reflect the input received. The state Care Programs team documents the finalized policies and incorporates changes into updates of this manual.

1.2 Managed Care Entity Orientation

When the MCEs contract with the state, the state schedules orientation sessions with the MCEs to review policy and technical procedures necessary to the contract administration. This includes interfaces with the state and its contractors before and after implementation of any contract. The MCEs identify individuals to participate in the initial and/or ongoing orientation sessions. Individuals participating would generally be from the following functional areas:

- Provider network development and enrollment, including primary medical providers (PMPs)
- Technical and systems support
- Medical policy
- Member services and enrollment
- Member financial obligations for premium payment programs
- Quality assurance and utilization review

The state designates members from its staff and contractor representatives to work with the MCE on implementation issues. During orientation, the state and its HIP contractors provide the MCE with a broad range of materials.

The fiscal agent, currently Gainwell, provides the following:

- Claim resolution edits and audits documents which are posted to File Exchange to the MCEs in January and July.
- *IHCP explanation of benefits (EOBs) codes* are available on the Explanation of Benefits page at in.gov/medicaid/providers
- *IHCP Provider Reference Modules* are available on the Provider Reference Materials page at in.gov/medicaid/providers.
- Financial cycle schedules for capitation payments.
- Schedules for generation of all other information to and from the MCEs.
- IHCP provider update bulletins and banner are available from the *News, Bulletins and Banners Pages* page at in.gov/medicaid/providers.
- Electronic file layouts and requirements for data exchanges, including provider extract files, POWER Account reconciliation file layout, and third-party liability files are available from the *MCE Secure Landing* page at in.gov/medicaid/partners. The username is *MCEhealthplans.* This website is password protected. MCEs can obtain the password by contacting their OMPP Contract Compliance Officer.
- User ID and password for access to electronic files, including *Health Insurance Portability and Accountability Act* (HIPAA)-compliant member enrollment rosters and capitation payments. Additional information about other electronic files and claim processing is provided in Information Systems.
- Companion guides for the 5010 HIPAA-compliant 834 Benefit Enrollment Transactions, 820 Capitation and POWER Payment Transactions, 835 Remittance Advice Transactions, 837 Professional and Encounter Claims Transactions, and 837 Institutional Claims and Encounter Transactions. The guides for upgrading to 5010 HIPAA-compliant transactions are available on the *IHCP Companion Guides* page at in.gov/medicaid/providers. This section contains structure and transaction specifications. The *IHCP Companion Guide Overview* and the IHCP Notes provide IHCP information. See the revision history document for specific updates. Providers and EDI vendors developing software for electronic data interchange may need to view multiple guides.
- MCE enrollment information, forms, and procedures are available on the *MCE Secure Landing* page at in.gov/medicaid/partners. The username is *MCEhealthplans*. This website is password protected. MCEs can obtain the password by contacting their OMPP Contract Compliance Officer.
- Procedures for PMP enrollment and disenrollment .
- Member MCE auto-assignment process for HIP.
- Agenda for the monthly MCE Technical Meeting, including format and procedure for submission of agenda topics.

The state or its designee provides the following:

- Orientation meeting schedule
- Resource-based relative value scale (RBRVS) and other relevant fee schedules
- Diagnosis-related group (DRG) information and base rates
- Telephone numbers for the state, enrollment broker, and fiscal agent contacts
- Annual IHCP report and other program summary reports
- Program meeting schedules
- Readiness review criteria
- Quarterly and ad-hoc reporting requirements and schedule

The enrollment broker provides the following materials:

- HIP member materials
- Enrollment broker script for member education and enrollment process
- In-service training opportunities

The state arranges orientation sessions for each newly contracted MCE. Orientation sessions are not automatically conducted for each contract renewal for an incumbent MCE. At the time of a contract renewal, an incumbent MCE can request the orientation session to accommodate changes in networks or other transitions for which the MCE believes an orientation session would be beneficial. The MCE must make this special request in writing to their contract compliance officer and ask whether it wishes to participate in the entire session or in a limited session to review specified topics.

Section 2: Managed Care Entity - Contractor Requirements

Managed care entities (MCEs) must comply with the following to participate in the Healthy Indiana Plan (HIP) program:

- Be an Indiana-licensed accident or sickness insurer, or an Indiana-licensed health maintenance organization (HMO).
- Be fully authorized under Indiana law to arrange or administer the full range and scope of services required under a procurement process undertaken by the state.
- Contract with the state on a prepaid, capitated basis to arrange, administer, and pay for the delivery of healthcare services to its members

As required by *IC 12-15-12-21*, if the MCE was an IHCP vendor before July 1, 2008, the MCE must be accredited by the National Committee for Quality Assurance (NCQA) on or before the contract start date. If MCE fails to attain accreditation, they must seek OMPP approval before contract start date. Request must include an explicit action plan of attainment.

Per 42 CFR 438.332(b)(1)-(3), 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.

Managed care entities must comply with the following to participate in the Hoosier Healthwise program:

- Be an Indiana-licensed accident or sickness insurer, or an Indiana-licensed health maintenance organization (HMO). Be fully authorized under Indiana law to arrange or administer the full range and scope of services required under a procurement process undertaken by the state.
- Contract with the state on a prepaid, capitated basis to arrange, administer, and pay for the delivery of healthcare services to its members.
- As required by *IC 12-15-12-21*, if the MCE was an IHCP vendor before July 1, 2008, the MCE must be accredited by the National Committee for Quality Assurance (NCQA) on or before the contract start date. If MCE fails to attain accreditation, they must seek OMPP approval before contract start date. Request must include an explicit action plan of attainment.
- Per 42 CFR 438.332(b)(1)-(3), 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.

2.1 State Licensure

Managed care entities (MCEs) must comply with the following to participate in the Hoosier Healthwise program:

- Be an Indiana-licensed accident or sickness insurer, or an Indiana-licensed health maintenance organization (HMO).
- Be fully authorized under Indiana law to arrange or administer the full range and scope of services required under a procurement process undertaken by the state.

- Contract with the state on a prepaid, capitated basis to arrange, administer, and pay for the delivery of healthcare services to its members.

2.2 National Committee for Quality Assurance (NCQA) Accreditation

As required by *IC 12-15-12-21*, if the MCE was an IHCP vendor before July 1, 2008, the MCE must be accredited by the National Committee for Quality Assurance (NCQA) on or before the contract start date.

If MCE fails to attain accreditation, they must seek OMPP approval before contract start date. Request must include an explicit action plan of attainment.

Per 42 CFR 438.332(b)(1)-(3), 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

2.3.1 Staffing

The MCE must ensure that all staff members, including subcontractor staff, have appropriate and ongoing training (for example, orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, computer systems, and so forth), education, and experience to fulfill the requirements of their positions. The MCE must institute mechanisms to maintain a high level of performance and data reporting, regardless of staff vacancies or turnover. The MCE must also have an effective method to mitigate the effects of staff turnover (for example, cross-training, use of temporary staff or consultants, and so forth). Processes must also be in place to solicit feedback from MCEs' staff members to improve the work environment. The MCE must maintain documentation to confirm internal training, curriculum, schedules, and attendance. The MCE must have descriptions for the positions discussed in this section. The descriptions must include the responsibilities of and qualifications for the position, for example, but must not be limited to education (for example, high school, college degree, or graduate degree), professional credentials (for example, licensure or certifications), direct work experience, and membership in professional or community associations.

The MCE must set up and maintain a business office or work site within five miles of downtown Indianapolis, IN, from which, at minimum, key staff members physically perform the majority of their daily duties and responsibilities, and a major portion of the plan's operations take place. The MCE 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 MCE 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 MCE'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 must be prepared to discuss these operations upon request, including during unannounced FSSA site visits.

Except in the circumstance of the unforeseeable loss of a key staff member's services, the MCE must provide written notification to the MCE's assigned contract compliance officer 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 MCE must present the State's contract compliance officer with an interim plan to cover the responsibilities created by the key staff vacancy. Likewise, the MCE shall notify the State's contract compliance officer 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. All key staff must be accessible to the state and its other program subcontractors via voice and electronic mail. The MCE must submit updated contact information for key staff as changes occur. Additionally, MCEs are required to review and complete a contact sheet on a quarterly basis.

2.3.2 Key Staff

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. The MCE must employ specific key staff dedicated as a full-time employee (FTE), and the state reserves the right to approve or deny the individuals in these positions. In addition to the key staff members, the MCE must also employ the additional staff necessary to ensure compliance with the state's performance requirements. The key staff members are as follows:

- Chief Executive Officer, President, or Executive Director – The Chief Executive Officer or Executive Director has full and final responsibility for the MCE management and compliance with all provisions of the Contract.
- Chief Financial Officer – The Chief Financial Officer must oversee the budget and accounting systems of the MCE for the HIP program. This Officer, at a minimum, must be responsible for ensuring that the MCE meets the State's requirements for financial performance and reporting.
- Compliance Officer – The MCE must employ a Compliance Officer who is accountable to the MCE's executive leadership and is dedicated full-time to the HIP program. This individual is the primary liaison with the State (or its designees) to facilitate communications between FSSA, the State's contractors, and the MCE's executive leadership and staff. This individual must maintain current knowledge of federal and state legislation, legislative initiatives, and regulations that may affect the HIP program. It is the responsibility of the Compliance Officer to coordinate reporting to the state 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 MCE functions are compliant with the terms of the Contract. The Compliance Officer must meet with the state's Family and Social Services Administration (FSSA) Program Integrity (PI) unit on a quarterly basis.
- Chief Information Officer (CIO) or Information Technology (IT) Director – The MCE must employ a CIO or IT Director who is dedicated full-time to the MCE's Indiana Medicaid product lines. This individual will oversee the MCE's HIP IT systems and serve as a liaison between the MCE and the State fiscal agent or other FSSA contractors regarding encounter claims submissions, capitation payment, member eligibility, 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 their place. This representative must report back to the CIO or IT Director on the Technical Meeting's agenda and action items.
- Medical Director – The MCE must employ the services of a Medical Director who is an Indiana-licensed Indiana Health Coverage Programs (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 must be dedicated full-time to the

MCE's Indiana Medicaid product lines. The Medical Director, in close coordination with other key staff, is responsible for ensuring that the medical management and quality management components of the MCE's operations are compliant with the terms of the MCE's contract with the state. The Medical Director is responsible for attending all State quality meetings, including the Quality Strategy Committee meetings. If the Medical Director is unable to attend a state quality meeting, the Medical Director must designate a representative to take their place. This representative must report to the medical director about the meeting's agenda and action items. The medical director must do the following:

  - Oversee the development and implementation of the MCE's disease management, case management, and care management programs.
  - Oversee the development of the MCE's clinical practice guidelines; review any potential quality of care problems.
  - Oversee the MCE's clinical management program and programs that address special needs populations.
  - Oversee health screenings and medically frail assessments.
  - Serve as the MCE's medical professional interface with the MCE's primary medical providers (PMPs) and specialty providers.
  - Direct the Quality Management and Utilization Management programs, including, but not limited to, monitoring, corrective actions, and other quality management, utilization management, or program integrity activities.

- Member Services Manager – The MCE must employ a Member Services Manager who is dedicated full-time to HIP member services, which must be available via the member help line and the member website, including through a member portal. The Member Services Manager must, at a minimum, be responsible for directing the activities of the MCE'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 is responsible for the member grievances and appeals process, and works closely with other managers (especially, the Quality Manager, Utilization Manager, and Medical Director) and departments to address and resolve member grievances and appeals. The Member Services Manager must oversee the interface with the enrollment broker and must provide an orientation and ongoing training for member services helpline representatives, at a minimum, to accurately inform members about how the MCE 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 the MCE's member services operations are compliant with the terms of the Contract.
- Provider Services Manager – The MCE must employ a Provider Services Manager who is dedicated full-time to the HIP program. The Provider Services Manager, at a minimum, must be responsible for the provider services helpline performance, provider recruitment, contracting and credentialing, facilitating the provider claim dispute process, developing and distributing the provider reference module and education materials, and developing outreach programs. The Provider Services Manager oversees the process of providing information to the State fiscal agent regarding the MCE's provider network, including PMPs, via the Portal. The Provider Services Manager, in close coordination with other key staff, is responsible for ensuring that all the MCE's provider services operations are compliant with the terms of the Contract.
- Special Investigation Unit Manager – The MCE shall employ a Special Investigation Unit (SIU) Manager who is dedicated full-time to the MCE'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 the FSSA and reducing or eliminating wasteful, fraudulent, or abusive healthcare billings and services. The SIU manager shall report to

the Compliance Officer and meet with the OMPP Program Integrity (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 unit managers.

- Quality Management Manager – The MCE shall employ a Quality Management Manager who is dedicated full-time to the MCE's Indiana Medicaid product lines. The Quality improvement management manager shall, at a minimum, be responsible for directing the activities of the MCE's quality management staff in monitoring and auditing the MCE's healthcare delivery system, including, but not limited to, internal processes and procedures, provider networks, service quality and clinical quality. The Quality Management Manager shall assist the MCE's compliance officer in overseeing the activities of the MCE's operations to meet the state's goal of providing healthcare services that improve the health status and health outcomes of HIP members.
- Utilization Management Manager – The MCE must employ a Utilization Management Manager who is dedicated full-time to the MCE's Indiana Medicaid product lines. The Utilization Management Manager, at a minimum, must be responsible for directing the activities of the utilization management staff. With direct supervision by the medical director, the utilization management manager must direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, appropriate utilization of healthcare services, continuity of care, care coordination, and other clinical and medical management requirements. The Utilization Management Manager shall work with the 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 business days to enable recovery of overpayments or other appropriate action.
- Behavioral Health Manager – The MCE must employ a Behavioral Health Manager who is dedicated full-time to the MCE's Indiana Medicaid product lines. The behavioral health manager is responsible for ensuring that the MCE's behavioral health operations, which include the operations of any behavioral health subcontractors, are compliant with the terms of the MCE's contract with the state. The Behavioral Health Manager must coordinate with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance, and reporting. The Behavioral Health Manager must 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 must work closely with the MCE'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 must collaborate with key staff to ensure the coordination of physical and behavioral healthcare. The Behavioral Health Manager must 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 must be the primary liaison with behavioral health community resources, including community mental health centers (CMHCs), and be responsible for all reporting related to the MCE's provision of behavioral health services.
  - If the MCE subcontracts with a managed behavioral health organization (MBHO) to provide behavioral health services, the Behavioral Health Manager will continue to work closely with the MCE's other managers to provide monitoring and oversight of the MBHO and to ensure the MBHO's compliance with the contract.
- Dental manager - The MCE 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 MCE must employ a Data Compliance Manager who is dedicated full-time to the MCE's Indiana Medicaid product lines. The Data Compliance Manager provides oversight to ensure the MCE's HIP data conform to Family and Social Services Administration (FSSA) and state data standards and policies. The data compliance manager must have extensive experience in managing data quality and data exchange processes, including data integration and data verification. The Data Compliance Manager must also be knowledgeable in healthcare data and healthcare data exchange standards. The data compliance manager manages data quality, change management, and data exchanges with the state. The data compliance manager is responsible for data quality and verification, data delivery, and change management processes used for data extract corrections and modification. The Data Compliance Manager also enforces data standards and policies for data exchanges to the state as defined by the FSSA data architect. The data compliance manager coordinates with the FSSA data architect to implement data exchange requirements.
- POWER Account Operations Manager – The MCE must employ a HIP POWER Account Operations Manager who is dedicated full-time to the HIP program's POWER Account operations. The POWER Account Operations Manager is responsible for overseeing the accurate and efficient administration of member POWER Accounts, including but not limited to: POWER Account contribution billing, reminders and collections; applying member, state, and third-party contributions; termination or transfer to *HIP Basic*, as applicable, for nonpayment; POWER Account Reconciliation files (PRFs); POWER Account statements; POWER Account reconciliation and rollover; POWER Account contribution recalculations; POWER Account transfers; and POWER Account reporting.
- Pharmacy Director – The MCE must employ a Pharmacy Director who is an Indiana-licensed pharmacist dedicated full-time to the MCE's Indiana Medicaid product lines. The pharmacy director shall oversee the pharmacy-related operations of the program and is ensure that the MCE's pharmacy benefits are compliant with the terms of the MCE's contract with the state. This individual shall represent the MCE at all meetings of the state's Drug Utilization Review (DUR) Board meetings and the Mental Health Quality Assurance Committee (MHQAC). If the MCE subcontracts with a Pharmacy Benefits Manager (PBM) for its HIP pharmaceutical services, the pharmacy director shall be responsible for oversight and contract compliance of the PBM, including pharmacy audits, as well as any other audits or responses.
- Transition Coordination Manager – The MCE must 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 MCE'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 member 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 MCE shall employ a Grievance and Appeals Manager responsible for managing the MCE's grievance and appeals process. This individual shall be

responsible for ensuring compliance with processing timelines and policy and procedure adherence as outlined in the MCE's contract with the state. The Grievance and Appeals Manager will ensure the MCE has appropriate representation and/or provides adequate documentation if a member appeals to the state.

- Claims Manager – The MCE shall employ a Claims Manager dedicated full-time to the MCE's Indiana Medicaid product lines and responsible for ensuring prompt and accurate provider claims processing in accordance with the terms of the MCE's contract. This individual shall work in collaboration with the CIO or IT Director to ensure the timely and accurate submission of encounter data. 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.

- Health Equity Officer – The Contractor must employ a full-time Health Equity Officer dedicated to Indiana Medicaid. The Health 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, economic, education and health status needs of those served by the Contractor.

2.3.3 Staff Positions

In addition to required key staff, the MCE must employ those additional staff necessary to ensure the MCE's compliance with the State's performance requirements. Required staff includes but are not limited to:

- Grievance and appeals staff – The MCE must employ staff necessary to investigate and coordinate responses to address member and provider grievances and appeals against the MCE and interface with the OMPP and the FSSA Office of Hearings and Appeals.
- Technical support services staff – The MCE must employ technical support services staff to ensure timely and efficient maintenance of information technology support services, production of reports and processing of data requests, and submission of encounter data.
- Quality management staff – The MCE must employ a quality management staff dedicated to performing quality management and improvement activities and participate in the MCE's internal Quality Management and Improvement Committee.
- Utilization and medical management staff – The MCE must employ utilization and medical management staff dedicated to performing utilization management and review activities.

- Case managers – The MCE must employ 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 must identify the needs and risks of the MCE'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 – The MCE must employ member services representatives to coordinate communications between the MCE and its members; respond to member inquiries; and assist all members regarding issues such as the MCE's policies, procedures, general operations, benefit coverage, and eligibility. Member services staff must have access to real-time data on members, including eligibility status, POWER Account contributions and transactions, PMP assignments, 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 – The MCE must employ member marketing and outreach staff to manage marketing and outreach efforts for the HIP programs, paying particular attention to eligible HIP parents and caretaker relatives.

- Compliance staff to support the Compliance Officer and help ensure all MCE 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 MCE's network and coordinate communications between the MCE 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 MCE, 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 MCE's programs, policies and procedures; and identify and address barriers to an effective health care delivery system for the MCE's members and providers.

- Special investigation unit staff – Supports the SIU manager and helps review and investigate the MCE's providers and members that are engaging in wasteful, abusive, or fraudulent billing or service utilization. The SIU staff 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 an SIU 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 the FSSA.

- Website staff – The MCE must employ website staff to maintain and update the MCE's member and provider websites and member portal.

- POWER Account collection staff – The MCE must employ POWER Account staff to support the MCE's HIP POWER Account operations and POWER Account contributions.

- Transition Coordination staff – The MCE must employ 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 MCE's Indiana Medicaid programs, as well as in and out of the MCE'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.

2.3.4 Training

The MCE must ensure that each staff person, including those of a subcontractor, 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 MCE must provide initial and ongoing training and must ensure all staff are trained in the major components of the HIP program. Staff training must 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, training on the MCE'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 MCE's utilization management guidelines. The ongoing training shall, at minimum, be conducted on a quarterly basis and as changes to the MCE'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 MCE 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

- Staff members with POWER Account responsibilities must receive detailed POWER Account education and training on topics including but not limited to the following:

- Billing and collections
- POWER Account contribution recalculations
- POWER Account impact of benefit plan transfers
- POWER Account rollover
- POWER Account termination
- POWER Account Reconciliation file (PRF)
- 820 transactions
- 834 transactions

The MCE must update its training materials on a regular basis to reflect program changes. The MCE must maintain documentation to confirm internal staff training, curricula, schedules and attendance, and must provide this information to the state on request and during regular on-site visits. The MCE must be prepared to provide, on request by the state, a written training plan, for utilization management and POWER Account that includes dates, subject matter, and training materials. For its utilization management staff, the MCE shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by the OMPP.

The MCE 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 MCE may request additional time to complete but FSSA is under no obligation to grant extensions. Each FSSA required training that is past due, without an approved extension, will be documented on the MCE Quarterly Scorecard. If the MCE is noticing issues accessing FSSA required trainings, the MCE shall communicate with their respective FSSA Contract Compliance Officer to discuss solutions.

2.3.5 Debarred Individuals

In accordance with *42 CFR 438.610*, which prohibits affiliations with individuals debarred by Federal agencies, the MCE must not knowingly have a relationship with the following:

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

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

In accordance with *42 CFR 438.610*, if FSSA finds that the MCE is in violation of this regulation, FSSA will notify the Secretary of noncompliance and determine if this Contract will be terminated.

The MCE shall have policies and procedures in place to routinely monitor staff positions and subcontractors for individuals debarred or excluded. As part of readiness review, the MCE shall demonstrate to the OMPP that it has mechanisms in place to monitor staff and subcontractors for individuals debarred by federal agencies.

The MCE shall be required to disclose to the FSSA PI Unit information required by *42 CFR 455.106* regarding the MCE's staff and persons with an ownership/controlling interest in the MCE that have been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or Title XX programs.

2.4 FSSA/OMPP Meeting Requirements

The state conducts meetings and collaborative workgroups for the HIP program. The MCE must comply with all meeting requirements established by the state and is expected to cooperate with the state and its contractors in preparing for and participating in these meetings. The state 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 state reserves the right to meet at least annually with the MCE's executive leadership to review the MCE's performance, discuss the MCE's outstanding or commendable contributions, identify areas for improvement, and outline upcoming issues that may impact the MCE or the HIP program.

2.5 Financial Stability

The state and the Indiana Department of Insurance (IDOI) monitor MCE financial performance and require submission of quarterly financial reports. The state includes IDOI findings in its monitoring activities. The MCE must copy the state on required filings with IDOI, and the required filings must break out financial information for the HIP line of business separately.

2.5.1 Solvency

The MCE must maintain a fiscally solvent operation per state and federal regulations and must meet IDOI requirements for minimum net worth, set reserve amount, and risk-based capital surplus. The MCE must have a process in place to review and authorize contracts established for reinsurance and third-party liability, if applicable.

The MCE must comply with federal requirements for protection against insolvency (pursuant to *42 CFR 438.116*), which require a non-federally qualified MCE to:

- Provide assurances satisfactory to the state that its provision against the risk of insolvency is adequate to ensure that its enrollees would not be liable for the MCE's debts if the MCE became insolvent.
- 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.

2.5.2 Insurance

The MCE must comply with all applicable insurance laws of Indiana and of the federal government throughout the term of the contract. No fewer than 90 calendar days before delivering services under this contract, the MCE must obtain Fidelity Bond or Fidelity Insurance from an insurance company authorized to do business in the state of Indiana.

This insurance coverage must be maintained throughout the term of the contract. No fewer than 30 calendar days before each policy's renewal effective date, the MCE must submit its certificate of insurance to the state for approval. The MCE must submit the certificate of insurance through the state-established document review process.

2.5.3 Reinsurance

The MCE must purchase reinsurance from a commercial reinsurer and must establish reinsurance agreements meeting the requirements as enumerated in the scope of work. The MCE must submit new policies, renewals, or amendments to the state for review and approval at least 120 calendar days

before becoming effective. The MCE must submit these through the state-established document review process.

2.5.3.1 Agreements and Coverage

The MCE's must adhere to and provide all agreements and proof of coverages listed below:

- The attachment point must be equal to or less than $200,000 and must apply to all services. The MCE electing to establish commercial reinsurance agreements with an attachment point greater than $200,000 must provide a justification in its proposal or submit justification to the state in writing at least 120 calendar days before the policy renewal date or date of the proposed change. The MCE must receive approval from the state before changing the attachment point.
- The MCE's co-insurance responsibilities above the attachment point shall be no greater than 20%.
- Reinsurance agreements must transfer risk from the MCE to the reinsurer.
- The reinsurer's payment to the MCE must 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 MCE must maintain a plan acceptable to the commissioner of the IDOI for the continuation of benefits in event of receivership. The MCE must finance the greater of $1 million or total projected costs, as calculated by the form set forth in *760 IAC 1-70-8*.
- The MCE must obtain continuation of coverage insurance (insolvency insurance) to continue plan benefits for members until the end of the period for which premiums are paid. This coverage must extend to members in acute care hospitals or nursing facilities when the MCE's insolvency occurs during the members' inpatient stays. The MCE must continue to reimburse for its members' care under those circumstances (such as inpatient stays) until members are discharged from the acute care setting or nursing facility.

2.5.3.2 Requirements for Reinsurance Companies

- The MCE must submit documentation proving that the reinsurer follows the National Association of Insurance Commissioners' (NAICs') Reinsurance Accounting Standards.
- The MCE 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.

2.5.3.3 Subcontractors

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

2.5.4 Financial Accounting Requirements

The MCE must maintain accounting records specific to the HIP program. These records must incorporate performance and financial data of subcontractors, particularly risk-bearing subcontractors, as appropriate. The MCE must maintain accounting records in accordance with IDOI requirements.

In accordance with *42 CFR 455.100-106*, the MCE must notify the state of any person or corporation with 5% or more ownership or controlling interest in the MCE and must submit financial statements

for these individuals or corporations. Annual audits must include an annual actuarial opinion of the MCE's incurred-but-not-received (IBNR) claims specific to the HIP program.

Authorized representatives or agents of state and federal governments must have access to the MCE's accounting records and to the accounting records of its subcontractors for review, analysis, inspection, audit, or reproduction (given reasonable notice and at reasonable times during the performance or retention contract period). The MCE must file financial and other information required by the IDOI with the state insurance commissioner.

Copies of any accounting records pertaining to the contract must be made available by the MCE to the state within 10 calendar days of receiving a written request from the state. If such original documentation is not presented as requested, the MCE must provide transportation, lodging, and subsistence at no cost for all state and federal representatives to carry out audit functions at the principal offices of the MCE or where such records are located. The FSSA, the state, the IDOI, and other state and federal agencies (and their respective authorized representatives or agent) must have access to all accounting and financial records of any individual, partnership, firm, or corporation, as the records relate to transactions with any department, board, commission, institution, or other state or federal agency connected with the contract.

The MCE must maintain financial records pertaining to the contract, including all claims records, for three 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*). Financial records must address matters of ownership, organization, and operation of the MCE's financial, medical, and other recordkeeping systems. However, accounting records pertaining to the contract must be retained until final resolution of all pending audit questions and for one year following the termination of any litigation relating to the contract (if the litigation has not terminated within the three-year period).

In addition, the state requires MCEs to produce the following financial information, on 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, and 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 intercompany 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

The MCE, if not federally qualified, must disclose to the state information on certain types of transactions it has with a *party of interest*, as defined in the *Public Health Service Act* (see *§§1903(m)(2)(A)(viii)* and *1903(m)(4)* of the *Social Security Act*).

A *party of interest* as defined in *§1318(b) of the Public Health Service Act* 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 5 percent 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 of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law
- Any organization in which a staff member who is a director, officer or partner has directly or indirectly a beneficial interest of more than five percent of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent of the assets of the HMO
- Any person directly or indirectly controlling, controlled by, or under common control with an HMO or
- Any spouse, child, or parent of an individual described in the previous bulleted subsections.

2.5.6 Types of Disclosure Transactions

Business transactions which shall be disclosed include the following:

- 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.
- 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 must be disclosed in the transactions between the MCE and a party in interest listed previously include the following:

- 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
- Justification of the reasonableness of each transaction

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

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

2.5.7 Medical Loss Ratio

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). The calculation must fully comply with 42 CFR 438.8(d)-(f) 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 Healthy Indiana Plan program shall be calculated separately from other managed care programs.
- For each MLR reporting year, a preliminary calculation will be performed with six months of incurred claims run-out, and a final calculation will be performed with 18 months of incurred claims run-out.
- Incurred claims reported in the MLR should relate only to members who were enrolled with the MCE 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 MCE 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 MCE should ensure all subcontracts provide for sufficient transparency to allow for this required reporting.

The MCE shall maintain, at minimum, a medical loss ratio (MLR) of 87% for the Healthy Indiana Plan line of business per 42 CFR 438.8(c). The State reserves the right to recoup excess capitation paid to the MCE in the event the MCE's MLR, as calculated by the State on an annual basis, is less than 87%.

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). In addition, the MCE is required to submit MLR reporting as described in the *MCE Reporting Manual.* The state reserves the right to recoup excess capitation paid to the MCE if the MCE's MLR, as calculated by the state on an annual basis, is less than 87%.

2.6 Subcontracts

The term *subcontracts* include contractual agreements between the MCE and healthcare providers or other ancillary medical providers. The term *subcontracts* include contracts between the MCE and another prepaid health plan, physician-hospital organization, any entity that performs delegated activities related to the state MCE contract, and any administrative entities not involved in the actual delivery of medical care. The state encourages the MCE to subcontract with entities located in Indiana. The state does not allow the MCE to subcontract with entities located overseas.

The state must approve all subcontracts and changes in subcontractors or material changes to subcontracting arrangements. The state may waive its right to review subcontracts and material

changes to subcontracts. This waiver does not constitute any future waivers of review for that or any additional subcontracts. 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. No subcontract may extend past the term of the contract the MCE has with the state. A reference to this provision and its requirement must be included in all provider agreements and subcontracts.

Subcontractor agreements do not terminate the legal responsibility of the MCE to the state to ensure that all activities under the contract are carried out. The MCE must oversee subcontractor activities and submit annual reports on its subcontractors' compliance, corrective actions, and outcomes of the MCE's monitoring activities. The MCE is accountable for any functions and responsibilities that it delegates.

The MCE must provide an indemnification clause in all subcontracts. This clause must indemnify and hold harmless the state of Indiana, its officers, and employees from all claims and suits, including court costs, attorneys' fees, and other expenses for injuries or damages sustained because of an act of omission of the MCE or the subcontractor.

This indemnification requirement does not extend to the contractual obligations and agreements between the MCE and healthcare providers, or other ancillary medical providers that have contracted with the MCE. The subcontracts must further provide that the state shall not provide such indemnification to the subcontractor.

If the MCE subcontracts with another prepaid health plan, physician-hospital organization, or other risk-bearing entity that accepts financial risk for services the MCE does not directly provide, the MCE must monitor the financial stability of the subcontractors with payments equal to or greater than 5% of premium/revenue. The MCE must obtain the following from the subcontractor each quarter:

- Statement of revenues and expenses
- Balance sheet
- Cash flows and changes in equity and fund balance
- IBNR estimates

At least annually, the MCE must obtain from the subcontractor audited financial statements, including a statement of revenues and expenses, balance sheet, cash flows and changes in equity or fund balance, and an actuarial opinion of the IBNR estimates. The MCE must make these documents available to the state on request.

The MCE must comply with *42 CFR 438.230* and the following subcontracting requirements:

- The MCE must obtain the state's approval before subcontracting any portion of the project's requirements. The MCE must give the state a written request and submit a draft contract or model provider agreement at least 60 calendar days before using a subcontractor. If the MCE changes the subcontractor contract, the MCE must submit the amendment for the state review and approval 60 calendar days before the revised contract's effective date. The state must approve changes in vendors for any previously approved subcontracts. All subcontracts must be submitted through the state document review process using the *Care Programs Subcontract Checklist.* The state will not review a subcontract that is submitted without the checklist attached.
- The MCE must evaluate prospective subcontractors' ability to perform delegated activities before subcontracting services associated with the HIP program.
- The MCE must 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. The written agreement must comply with and is subject to the provisions of all Indiana statutes. The subcontract cannot extend beyond the term of the state's contract with the MCE.

- The MCE must collect performance and financial data from its subcontractors; monitor delegated performance on an ongoing basis; and conduct formal, periodic, and random reviews, as directed by the state. The MCE must incorporate all subcontractors' data into the MCE's performance and financial data for a comprehensive evaluation of the MCE's performance and, when appropriate, identify areas for its subcontractors' improvement. The MCE must take corrective action if deficiencies are identified during a review.
- All subcontractors must fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract.
- The MCE must comply with all subcontract requirements specified in *42 CFR 438.230*.
- The MCE must submit a plan to the OMPP to describe how the subcontractor will be monitored for debarred employees.
- All subcontracts, provider contracts, agreements, or other arrangements by which the MCE intends to deliver services must be subject to review and approval by the state and must be sufficient to ensure the fulfillment of the requirements of *42 CFR 434.6*. In accordance with *IC 12-15-30-5(b)*, subcontract agreements terminate when the MCE's contract with the state terminates.

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

The state reserves the right to audit the MCE's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. The state may require corrective actions and will assess liquidated damages, as specified in Exhibits 3 and 4 of the contract, for noncompliance with reporting requirements and performance standards.

If the MCE uses subcontractors to provide direct services to members, such as behavioral health services, the subcontractors must meet the same requirements as the MCE, and the MCE must demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The MCE must 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 MCE may choose to subcontract claims processing functions, or portions of those functions, with a state-approved subcontractor, the MCE must 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 MCE 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 MCE's responsibility to ensure that the subcontracting organizations forward claims to the appropriate processing entity. Using this type of method will not lengthen the timeliness standards for claims processing. 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 Members' Medical Records and Other Information

The MCE must ensure that members' 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). The MCE must also comply with all other applicable state and federal privacy and confidentiality requirements.

2.8 Internet Quorum Inquiries

The MCE must respond to Internet Quorum (IQ) inquiries within the time frame set forth by the state. The state forwards all IQs via email to the MCE compliance officer. When forwarding an IQ inquiry to the MCE for a response, the state will designate that the inquiry is an IQ inquiry and identify when the MCE's response is due. IQ inquiries typically include member, provider, and other constituent concerns and require a prompt response. The MCE's failure to provide a timely and satisfactory response to IQ inquiries, as determined by the state contract analyst, will subject the MCE to the liquidated damages set forth in Exhibit 4 of the contract. A satisfactory response must include sufficient information to enable the state to respond to the inquiry thoroughly and accurately within the time frames given. When applicable, the state may request additional details to determine what caused the issue to arise and how the MCE plans to mitigate the issue moving forward.

2.9 Material Changes

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, more than 5% of the MCE's membership or provider network.

Before implementing a material change in operation, the MCE shall submit a request to the state for review and approval at least 60 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. The MCE must communicate material changes to members or providers at least 30 days before the effective date of the change. Any member or provider communication material is subject to the review and approval of the state.

2.10 Data Requests

MCEs can submit data requests to the state for statistics to help manage their member populations. These data requests are produced by the state Data Management Unit. The MCEs are not allowed to make data requests to any other state-contracted entities, such as the state fiscal agent.

The MCE representative should contact their contract manager to make a data request.

The state reviews the data request to determine whether the data will be provided. Data will not be provided for the following scenarios:

- The MCE has access to this data via another mechanism (such as via the 834 enrollment roster).
- There are HIPAA concerns. Data is not released for non-MCE enrolled members.

If the state approves the data request, the state contract manager creates a data request with FSSA Data and Analytics. If the state denies the data request, the state contract manager notifies the MCE representative via email that the requested data will not be produced and why.

After the data request is complete, the state FSSA Data and Analytics team sends the data to the state contract manager for review. The state contract manager reviews the data and forwards it to the MCE representative to complete the process.

Section 3: HIP Plan Design and Member Eligibility

3.1 HIP Plus

HIP Plus (MARP) is available for all members enrolled in HIP who choose to make their POWER Account contribution. Individuals in *HIP Plus* make a POWER Account contribution and do not have copayments for services. They have a copayment for nonemergent use of the emergency department (ED).

3.1.1 Low Income Adults

In 2015, HIP was changed to provide healthcare coverage to all non-disabled low-income adults between the ages of 19 and 64 with household income at or below 138% federal poverty level (FPL). This change included the transition to HIP of many members who were previously enrolled in Hoosier Healthwise. This transition to HIP promoted better health outcomes for individuals, but also reduced churn between the programs, created administrative efficiencies, and provided a seamless experience for the members. In addition, the POWER Account changed from a $1,100 deductible to a $2,500 deductible while still including first-dollar coverage for preventive services. The annual and lifetime caps were also removed from the plan.

3.2 HIP Basic

HIP Basic (MARB) is the default option for members with income at or below 100% FPL, which does not take into account the 5% cost-share, who fail to make a POWER Account contribution. *HIP Basic* requires the member to make copayments at the point of service for services received from a provider, with the exception of preventive services. Individuals enrolled in *HIP Basic* are allowed to reenroll in *HIP Plus* upon their annual redetermination if they choose to begin paying their POWER Account contributions.

3.2.1 HIP Basic Potential Plus

Individuals enrolled in *HIP Basic* are allowed to reenroll in *HIP Plus* upon their annual redetermination if they choose to begin paying their POWER Account contributions.

3.2.2 Low Income Adults

In 2015, HIP was changed to provide healthcare coverage to all non-disabled low-income adults between the ages of 19 and 64 with household income at or below 138% federal poverty level (FPL). This change included the transition to HIP of many members who were previously enrolled in Hoosier Healthwise. This transition to HIP promoted better health outcomes for individuals, but also reduced churn between the programs, created administrative efficiencies, and provided a seamless experience for the members. In addition, the POWER Account changed from a $1,100 deductible to a $2,500 deductible while still including first-dollar coverage for preventive services. The annual and lifetime caps were also removed from the plan.

3.3 HIP State Plan

Individuals enrolled in *HIP State Plan Plus* (MASP) benefits have access to the greater benefit package available under the *State Plan*. Those in *State Plan Plus* have the same cost-sharing requirements as *HIP Plus*, they must make a POWER Account contribution, and they do not have copayments for services.

3.3.1 Low Income Adults

In 2015, HIP was changed to provide healthcare coverage to all non-disabled low-income adults between the ages of 19 and 64 with household income at or below 138% federal poverty level (FPL). This change included the transition to HIP of many members who were previously enrolled in Hoosier Healthwise. This transition to HIP promoted better health outcomes for individuals, but also reduced churn between the programs, created administrative efficiencies, and provided a seamless experience for the members. In addition, the POWER Account changed from a $1,100 deductible to a $2,500 deductible while still including first-dollar coverage for preventive services. The annual and lifetime caps were also removed from the plan.

3.3.2 Medically Frail HIP Members

Consistent with *42 CFR §440.315(f*), a HIP member will be considered medically frail if he or she has one or more of the following:

- A disabling mental disorder
- A chronic substance abuse disorder
- Serious and complex medical conditions
- Physical, intellectual, or developmental disability that significantly impair the individual's ability to perform one or more activities of daily living
- A disability determination based on Social Security Administration criteria

The medically frail process is operationalized utilizing the Milliman Medical Underwriting Guidelines, which assigns a point value to health conditions, including behavioral health and substance use disorders. Members who have verified conditions and meet the specified medically frail debit point thresholds using the Milliman Medical Underwriting Guidelines are eligible to receive State Plan benefits. The provision of State Plan benefits will not change the underlying HIP program plan in which the member is enrolled. For example, a member enrolled in *HIP Basic* who is determined medically frail are transferred to *HIP State Plan Basic* benefits, while a member enrolled in *HIP Plus* are transferred to *HIP State Plan Plus*. *HIP State Plan Basic* and *HIP State Plan Plus* are provided by the same MCEs and have the same cost-sharing structures as the standard *HIP Basic* and *HIP Plus* plans. However, the State Plan benefit package for medically frail members provides additional benefits that are not covered in the *HIP Basic* or *HIP Plus* plans.

3.3.2.1 Identifying Medically Frail Members

Each MCE is responsible for identifying and verifying all of its members who are medically frail. Notwithstanding the foregoing, members with a disability determination based on Social Security Administration criteria or members who are confirmed to have HIV or AIDS by the Indiana State Department of Health are automatically confirmed medically frail by the state. The MCE will not be responsible for verifying the medically frail designation of the members identified as such by the state, and such members are directly opened into *HIP State Plan* benefits.

The HIP member's MCE will verify the member's frail status through claims or supplemental information utilizing the Milliman Medical Underwriting Guidelines. Medically frail members may self-identify to their MCE at any point during the year by reporting that they believe they may qualify for medically frail status. MCEs have 30 calendar days from the date the member self-reported to the MCE to determine if the member is medically frail. In addition, MCEs may also independently identify a member as medically frail at any time during the year based on the member's medical and/or pharmacy claims history.

The MCE may identify potentially medically frail members through the following methods:

- Member claims data
- Results of Health Needs Screen and/or Comprehensive Health Assessment
- Member self-identification
- Provider identification
- Member appeal

The MCE shall establish processes to allow current members to self-identify as medically frail and for providers to identify members to the MCE as potentially medically frail. If requested by the member or by a provider on behalf of the member, then the MCE shall conduct a medically frail assessment within 30 calendar days from the date in which the member or provider, as applicable, contacted the MCE. Members who self-report medically frail status but who cannot be confirmed medically frail must receive written notice from the MCE that their condition could not be confirmed or does not qualify them for medically frail status. Members must be notified of the outcome of the assessment within three business days of the completed assessment.

3.3.2.2 Medically Frail Assessment

After a member has been identified as potentially medically frail, the MCE must use the Milliman Medical Underwriting Guidelines ("Milliman Guidelines") to designate the member as medically frail. A HIP member may be designated as medically frail at any time during the member's 12-month benefit period, provided such designation is supported by the Milliman Guidelines. After being designated as medically frail, the member's medically frail status is active for 12 months from the original confirmation date. If the MCE receives information during the 12-month period that would make them suspect that the member is not medically frail or that the confirmation was made in error, then the MCE must take action to revoke the member's medically frail status and provide the member with the opportunity to appeal such action as noted in the following.

The MCE must apply the Milliman Guidelines to the member's claims history to generate debit points for the member. If claims data is not available, the MCE must manually apply the Milliman Guidelines to the information obtained in the initial health needs screen and comprehensive health assessment or submitted medical records.

Members qualify as medically frail based on the member's qualifying conditions and related risk scores as follows:

- 150 debit points for indicated medical conditions
- 75 debit points for indicated behavioral health conditions
- 75 debit points for indicated substance abuse conditions
- 150 debit points for any combination of indicated medical, behavioral health, or substance abuse conditions
- Needs assistance with one of the activities of daily living (ADL) based on ADL screener

If the results of applying the Milliman Guidelines supports a medically frail designation, then the MCE must document and support the decision. Documentation must include, but is not limited to, all the following, as applicable:

- Output files from the Milliman Renewal MUGs tool indicating the number of debit points the member accumulated
- Completed comprehensive health assessment tool
- Documentation of attempts to make contact with their member and/or physician(s)
- Recorded responses to the ADL screener and supporting information indicating member impairment in ADLs
- Supplemental information gathered by the MCE to make a complete decision (such as lab results, physician notes, or lifestyle factors)

The MCE shall notify the state's fiscal agent within one business day of making any affirmative medically frail determination. If the MCE determines a member is not medically frail, then the MCE shall notify the state's fiscal agent within one business day of making the determination only if the determination would change a member's current benefit package.

The notice to the state's fiscal agent must identify:

- The medically frail designation
- The date of the medically frail determination, and
- After the supplemental file is available, the method used by the MCE to make the medically frail determination, specifically, whether the MCE relied solely on the Milliman Guidelines or if supplemental information was relied upon.

If the MCE relied on supplemental information, then the MCE shall maintain documentation of all information used to support the medically frail determination. The state will develop a form and a process by which the MCE may submit this information to the state's fiscal agent. After the form and process is developed, the MCE shall submit a Medically Frail Supplemental File to the state's fiscal agent monthly in a format specified by the state, which contains a generic description of the supplemental information used by the MCE to support the medically frail designation. The state will use this information to conduct audits of the MCE's medically frail determinations. At all times, the MCEs must maintain all documentation, generate high-level and detailed reports on their medically frail population, and provide member data for audit purposes as requested by the state.

Upon receipt of the medically frail determination, the state will transfer the member to the appropriate benefit package effective the first day of the month following receipt of the medically frail determination.

MCEs may apply the Milliman Guidelines in an automated fashion against member claims data on a monthly basis to all HIP membership to confirm or reconfirm member medically frail status.

3.3.2.3 Medically Frail Notice and Appeals

The MCE must provide written notice to any member whose benefits will change due to the MCE's medically frail designation, regardless of how the member was identified to the MCE. In addition, the MCE must provide written notice of the MCE's medically frail designation to any member who self-identified as medically frail or who was identified by a provider as potentially medically frail, regardless of whether the determination will impact member benefits. The written notice of medically frail determination must include the following information: (i) the medically frail determination; (ii) if applicable, the reason for a denial; (iii) any resulting changes to the member's benefits; and (iv) a description of the member's right to file an appeal, including the process for requesting an appeal from the MCE. MCE notices must include required language as designated by the state and notices must be

approved through the standard approval process before being sent to members. If the member was identified to the MCE by the member's provider, then a notification of the final determination must also be sent to the referring provider. The MCE must provide this notice within three business days of the determination being made.

Members, or providers acting on the member's behalf in accordance with *42 CFR 438.402*, shall have 60 calendar days from the date of action notice within which to file an appeal to the MCE. The MCE shall process and dispose of all medically frail appeals in accordance with the MCE's standard grievance and appeals process as detailed in Section 4.9 of the Scope of Work. Upon final resolution of the member appeal with the MCE, the MCE shall provide written notice of the resolution to the member as specified in the following:

- For appeals not resolved wholly in favor of the member, the notice shall also include information regarding the member's right to request a 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 notice must incorporate the state fair hearing language as provided by the state.
- For appeals that result in the member's medically frail status being confirmed, the MCE may systematically confirm the member's medically frail status on a going-forward basis only. The MCE may also request through the Rapid Response Team (RRT) process that the state back-date the medically frail status to no earlier than the first day of the month in which the notice is dated that the member was found not to meet the medically frail criteria.

For member adverse action appeals related to the MCE'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 MCE 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 MCE should send a frail = 'Y' indicator through the state's fiscal agent. The MCE 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 MCE should not send a frail 'Y' during the appeal for these members. If the final resolution of the medically frail appeal with the MCE determines that the member is medically frail, the MCE shall provide written notice to the member stating that their medically frail status has been confirmed and update the existing frail confirmation reasons within the file. If the member's medically frail status could not be confirmed upon appeal to meet the medically frail criteria, the MCE shall provide written notice to the individual that they do not meet the medically frail criteria, including an explanation as to how the determination was made, and detailing their state appeal rights as provided by the state. The MCE shall change the member's medically frail status in the member record from "Y" to "N" and submit the change to the state's fiscal agent.

If a member timely appeals an adverse appeal decision to the state following the MCE's final notice, then the state will ask for the MCE to confirm if the member exhausted their appeal rights with the MCE. Upon receipt of a request from the State Office of Administrative Law Proceedings (OALP), the MCE shall confirm whether the member has exhausted their MCE appeal process within two business days of receiving notification of the member's request for a state fair hearing. In addition, if requested by the FSSA, the MCE shall promptly respond to all requests for documentation required for the state fair hearing within the timeframes identified in the specific request.

If the member's State Plan benefits are reinstated and backdated following a state fair hearing decision, then the MCE shall send a medically frail confirmation to the state within two business days of the decision and the state shall, as applicable, back-date the medically frail confirmation to the date specified by the hearings and appeals decision.

3.3.2.4 Medically Frail Annual Review

The MCE must maintain documentation that every medically frail member meets the specific medically frail criteria, as set forth by the FSSA, for receipt of *HIP State Plan* benefits. For members initially determined medically frail by the MCE, the MCE must confirm a member's medically frail status at least once every 12 months in accordance with a process determined by the FSSA. At minimum, the MCE 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. For members initially determined medically frail by the state, the MCE shall confirm medically frail status by conducting a review of the member's claim history and/or pharmacy data against the Milliman Guidelines only when requested by the state in accordance with the timeframe and process determined by the FSSA.

Following the completion of the annual medically frail confirmation, the MCE shall notify the state's fiscal agent of the results, including any updated medically frail diagnostic indicators, no later than 15 calendar days before the one-year anniversary of the MCE's previous medically frail determination or confirmation, as applicable.

If a member is determined to no longer be medically frail, then the member is transferred to either:

- *HIP Plus* if they are currently making the required POWER Account contributions, or if they have income over 100% FPL, or
- *HIP Basic* if they are currently paying copayments at the time of service and have income at or below 100% FPL.
    - The MCE is required to send a member notice with appeal rights and follow the procedures indicated previously for members losing medically frail benefits.

If the member's medically frail status is expiring at the end of their benefit period and the member is transferring to another MCE, then the original MCE is responsible for the member's medically frail appeal. If the member's medically frail status expires after the transfer, then the new MCE is responsible for managing the member's medically frail appeal. MCEs are expected to share information to support the confirmation of medically frail status for individuals who transition to another MCE at or near the time their medically frail status is set to expire.

3.3.2.5 State Audit

The state will conduct regular audits of the MCE's medically frail confirmations to determine appropriate identification and placement of medically frail members. The state anticipates that less than ten percent (10%) of the MCE's total newly eligible adult HIP population will be designated as medically frail. The MCE shall consistently apply the Milliman Guidelines to every medically frail determination and review. Before the implementation of the monthly Medically Frail Supplemental File, the MCE is responsible for submitting to the state, upon request, generalized data on its medically frail confirmations as well as specific details, including all documentation and supplemental information requested for specific members selected for detailed audit. The MCE shall consistently apply the comprehensive health assessment tool and Milliman Guidelines to every medically frail determination and review.

3.4 Pregnancy Coverage Under HIP

HIP members who become pregnant will be transitioned to *HIP Maternity* for their pregnancy and 12-month postpartum period. Pregnant HIP members will not have cost-sharing requirements and will have enhanced services.

3.5 Presumptive Eligibility

Presumptive eligibility (PE) provides immediate, temporary coverage for certain groups of individuals who are likely to be eligible for HIP or other Medicaid coverage, including low-income parents or caretakers, non-disabled adults (ages 19-64 years), and former foster care children, as determined by a qualified hospital, provider, or other authorized entity.

Individuals determined presumptively eligible for HIP will be in the fee-for-service program until their eligibility is determined.

The PE process allows qualified acute care and psychiatric hospitals, federally qualified health clinics (FQHCs), rural health clinics (RHCs), community mental health centers (CMHCs), and local health departments to make PE determinations. Qualified PE providers make a preliminary assessment of eligibility based on a short list of eligibility questions, including age, income, pregnancy status, and residency status. Individuals found presumptively eligible have temporary health coverage starting that same day. The member receives a PE acceptance letter that serves as proof of coverage during the temporary PE coverage period. Members who are found eligible in other categories (not Adult PE) are placed in the fee-for-service program, and their benefits last until the last day of the month following their PE determination or, if they apply to the IHCP, until a decision is made on their IHCP application.

3.5.1 MCE Responsibilities During PE

3.5.1.1 Eligibility

Individuals determined presumptively eligible (PE) for HIP in accordance will be enrolled with an MCE for a presumptively eligible period.

The PE applicant is able to select an MCE at the time of PE application. If an applicant fails to select an MCE at the state will auto-assign the applicant to an MCE according to the state's auto-assignment methodology.

The MCE must conduct outreach to PE members to encourage them to complete an IHCP application for health benefits within their PE period. The MCE must work with their authorized QP providers to ensure that PE members are provided information at the time of the presumptive eligibility determination regarding the importance of completing an application for health coverage. Such education should also encourage members to include their unique presumptive eligibility MID on their IHCP application.

- The presumptive eligibility period ends when one of the following occurs:
    - A member has not filed an Indiana Application for Health Coverage by the last day of the month following the month in which their PE period began; or
    - A determination has been made on the individual's Indiana Application for Health Coverage.
- The PE period will end when the member does not complete and file an a IHCP application for health benefits by the end of the month following the month in which PE coverage begins
- A PE period for a member whose IHCP application for health benefits has been filed and denied by the FSSA will end effective the date the state makes the adverse eligibility decision on the member's application.

3.5.1.2 Presumptive Eligibility (PE) Covered Services and Provider Access

When a PE member is determined to be presumptively eligible by a QP outside the MCE's network, the MCE must work with the QP to provide reimbursement for the initial services rendered to the member.

3.5.1.2.1 PA and Appeal Rights

The MCE must have processes in place to provide prior authorization (PA) or prior approval (PA) for services rendered to PE members from the date that their PE eligibility is established. This date may pre-date the MCEs being able to see the member in Provider Health Care Portal

MCEs can use a copy or fax of the member's PE approval letter as evidence of PE eligibility before the member's file is sent from Hospital PE to the MCE. MCEs may ask providers to hold claims and submit them after eligibility is established. A temporary PA may be used for members who are not yet loaded into the MCE's system. The MCE may use a retrospective PA process for PE members.

3.5.1.3 Important Presumptive Eligibility Capitation Information

- Capitation is based on the MCE and PMP assignment. Two active assignments in one month (for instance, one PE assignment and one HIP assignment) could equal two full capitation payments. This could happen with HIP alone; it most often happens in combination with PE. As long as a member has two Member IDs that are not linked during a month and two MCE and PMP assignments, capitation is paid for both Member IDs and assignments. Also, the linked Member IDs do not mean that capitation is not paid under both, because there could be active PMP assignments under the PE MID and the 1099 MID.
- If a member has PE for a portion of a month and HIP for a portion of a month, the capitation rate is based on the MCE and PMP assignment and pays accordingly. If the MCE assignment changes from one MCE to another, capitation would pay to both MCEs, based on the assignment dates. A member assignment for 17 days or less results in half capitation, and an assignment of 18 days or more results in a full capitation payment.
- If member has PE regardless of Medicaid history (with or without prior IHCP eligibility) and she is determined ineligible for Medicaid, capitation is paid, as long as the PE segment is active and there is an MCE assignment for the PE period. Capitation is not recouped from an MCE for a PE member if she is determined ineligible for Medicaid.
- There are times when a member's PE segment is not closed by the DFR caseworker after Medicaid eligibility is granted. Because of the two active assignments, duplicate capitation is paid for Hoosier Healthwise and PE. When the PE segment is eventually identified and closed, the fiscal agent recoups the duplicate payments. If the PMP assignment is retroactively ended, the systematic capitation reconciliation process recoups back to the end date of the assignment. If the PE PMP assignment is removed, capitation reconciliation recoups all capitation payments formerly covered by the PE PMP assignment that no longer exists.
- Regardless of whether the PE member is granted bisect eligibility, retroactive eligibility, or future-dated eligibility, capitation is based on the MCE and PMP assignment. If the MCE and PMP assignment is open and active, capitation is paid. However, variables can occur that affect the capitation rate such as:
    - Changes in aid category – For all other aid categories, including PE, gender and age are the deciding factors and determine the capitation rate.
    - Change in member's residence
    - Change of gender

Section 4: Billing and Collections

4.1 Individual Cost-Sharing Obligations

The managed care entities (MCEs) will provide all Healthy Indiana Plan (HIP) members with a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) Account, which operates similar to a Health Savings Account (HSA) and is used to fund a $2,500 deductible. The initial state contribution to a member's POWER Account is $1,300.

The MCE'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 MCE shall ensure that its HIP members are placed in the appropriate benefit category and that billing and collections activities are appropriate for the member's benefit category. All HIP members will have a calendar year benefit period – even if they leave the program and return – and will also have the same MCE for that time. New members are able to select their MCE at the time of application and ongoing members are able to change MCEs during the MCE selection period in the fall, which is described in *Member Enrollment*.

The HIP benefit categories are as follows:

4.1.1 HIP Plus Member Cost Sharing

All HIP eligible members will initially be given the opportunity of an enhanced benefit package (*HIP Plus*). *HIP Plus* participation requires members to make monthly POWER Account contributions (PACs), except for individuals exempt from cost-sharing. Member eligibility in *HIP Plus* shall not be final until either the first PAC or Fast Track prepayment is paid. To remain fully eligible for *HIP Plus*, members must continually make monthly POWER Account contributions.

4.1.2 HIP Basic Member Cost Sharing

HIP members with income at or below 100% FPL who do not make an initial Fast Track prepayment or initial and subsequent PACs are not eligible for *HIP Plus*, and are transferred to this category, a more limited benefit package that requires copayments for services.

4.1.3 HIP Basic with Potential Plus Opportunity

HIP members who were unsuspended from an incarcerated status, transitioned to HIP from other Medicaid coverage, or have earned POWER Account rollover are opened into *HIP Basic* coverage with the opportunity to make a PAC payment and gain *HIP Plus* coverage.

4.1.4 HIP State Plan Member Cost Sharing

The MCE shall provide *HIP State Plan* benefits to HIP members meeting any of these eligibility criteria:

- Section 1931 eligible parents and caretaker relatives eligible under *42 CFR 435.110*
- Low-income 19- and 20-year-old dependents eligible under *42 CFR 435.222*
- Members determined eligible for transitional medical assistance (TMA) by the state in accordance with S*ection 1925 of the Social Security Act*

- Individuals determined to be medically frail

4.1.5 HIP Maternity

This plan offers access to all benefits available under the *State Plan*, with no cost-sharing, to pregnant women who are enrolled in or determined eligible for HIP. *HIP Maternity* offers enhanced benefits during the member's pregnancy, including vision, dental, and chiropractic services; nonemergency transportation; and enhanced tobacco dependence services.

4.1.6 Exempt Populations

Unless otherwise exempt from cost-sharing, all members receiving *HIP State Plan* benefits will pay monthly PACs consistent with the *HIP Plus* plan (*HIP State Plan Plus*), or, if at or below 100% federal poverty level (FPL), pay copayments for services as required under the *HIP Basic* plan (*HIP State Plan Basic*). There is also a category under *HIP State Plan Plus* in which copayments are required (*HIP State Plan Plus Copay*). A member falls into this category if they fail to make PACs, have income above 100% FPL, and are medically frail.

All non-exempt HIP-eligible individuals are responsible for making financial contributions toward the cost of their healthcare coverage whether it is through PACs for those enrolled in *HIP Plus* or through copayments assessed at the point of service for those enrolled in *HIP Basic*. The MCE is responsible for billing, collecting, and applying these member payments.

Members exempt from making financial contributions are as follows:

- Pregnant women
- Native Americans
- Cost-share Met – 5% members

4.1.7 Tobacco Use Surcharge

Members will self-identify as tobacco users during their initial application, during MCE selection, or when a member notifies their MCE. Members who are identified as tobacco users will be tracked for the first benefit period until December 15 each year. The surcharge will be assessed the second benefit period if at MCE selection the member continues to identify as a tobacco user. MCEs will track member tobacco via self-attestation. Members are assessed based on 12 months of tracking and eligibility. If a member was fully eligible since January 1, 2018, and a tobacco user as indicated by a "Y" for "yes", as of January 1, 2018, by December 15, 2018, they will be assessed a surcharge for the new benefit period beginning January 2019.

The determination to charge a surcharge is only assessed at the beginning of the benefit period by the MCE. Changes to the surcharge cannot be made mid-benefit period without going through the grievance process. At the time of MCE selection, if the member was identified as a tobacco user the previous year and is still using tobacco as of January 1 of the next year, they will be assessed the surcharge. If the member has quit using tobacco, they can have this changed only during MCE selection.

If a member accidentally marks "yes" to the tobacco use questions and meant to mark "no," the MCE and enrollment broker have the ability to correct the error in the system. The MCE or the enrollment broker will need to verify it was marked "yes" by mistake. If the member was a tobacco user at the time they submitted the application, the enrollment broker should leave the field as "yes." If a member went through the MCE selection process and is still identified as a tobacco user in their second benefit

period, they need to go through the grievance process with the MCE to have the "yes" indicator changed to "no."

A member who has been identified for tobacco use can notify the MCE that they have stopped using tobacco in one of the following methods: member tobacco use self-attestation, and member notification of tobacco use to the MCE or the enrollment broker during MCE selection. If the member has entered the second benefit period and the surcharge has been assessed, the only way the member could remove their tobacco use status is to go through the grievance process with the MCE.

MCEs will track and bill the surcharge on monthly POWER Account statements. PAC amounts will be determined by the eligibility system using the normal procedure. MCEs must separate the surcharge from the standard PAC on invoicing to highlight the additional cost due to tobacco use for the fully eligible members (*HIP Basic Potential Plus* members included). Members who have a surcharge and then become 5% cost-share met will have a $1.50 PAC. Similarly, those who have 5% cost-share met and are later assessed a surcharge will have a $1.50 PAC.

Table 1 – Tobacco Use Surcharge and POWER Account Contribution Combined Amounts

Income as Percentage of 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

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.

The tobacco surcharge must be taken into account when reconciling the POWER Accounts effective the 2019 calendar year benefit period. The first time MCEs will reconcile a POWER Account with a tobacco surcharge is in 2020.

When account reconciliation is done for individuals with a surcharge, the surcharge counts as part of the individual's required contribution. The state's portion of the $2,500 account is: $2,500 - PAC owed - surcharge owed.

Overpayments should ***always*** be refunded. Because current year overpayments are always refunded to the member, the member's rollover can never be more than $240. A tobacco surcharge member may earn up to $360 in member rollover. However, since the maximum amount of member rollover allowed on the IR/FR/IX/FX PRF submission is $240 and the rest will be refunded to the member as a current year overpayment. Any member rollover amounts over $240 will be refunded as a current-year overpayment.

Core Medicaid Management Information System (*Core*MMIS) will store the tobacco use indicator and date and pass it to the MCE on fully eligible members only. The tobacco use indicator may be updated by the MCE via a supplemental file at any time. The indicator is updated when an individual self-

attests to using or not using tobacco. After updated via the supplemental file, the indicator is passed back to the MCE on the 834.

The indicator exists for all HIP fully eligible enrollees regardless of benefit or cost-sharing plan (for example, *HIP Plus*, *HIP Basic*, *HIP State Plan*, and No-Cost-share). The fiscal agent will send a change record to the MCE when the indicator changes effective date or indicator status Y/N. The fiscal agent will not overwrite an MCE- or enrollment broker-reported Y indicator with an N indicator from Indiana Eligibility Determination and Services System (IEDSS) for past dates or with no date associated.

When an individual changes MCEs during the selection period or middle of the year, the tobacco indicator is passed to the new MCE. However, because the surcharge is based on 12 months of full eligibility and tracking of tobacco use, the new MCE will not know the member's previous tobacco use indicator or be expected to apply a surcharge.

MCEs will be asked to provide reports on the tobacco surcharge. Reports will be defined at a future date but may include items such as the number of individuals that are assessed a surcharge or the number of grievances regarding the tobacco surcharge. Auditing may be done to assess how many individuals access tobacco cessation services but have not indicated previously that they use tobacco.

Plans are not required to notify members of the potential for a surcharge when they self-report that they use tobacco, such as via a Health Needs Screen (HNS). This data field, which determines the surcharge, should not be updated when members report tobacco use as part of the HNS.

Tobacco use information collected through the HNS or claims data can be used to refute a member who is being assessed a surcharge and tries to have it removed via the MCE grievance process, but not to initially mark a member as a tobacco user.

4.2 POWER Accounts and Copayments

The MCE must establish and administer a POWER Account for each HIP member. All HIP members will have a POWER Account regardless of the member's specific benefit package (*HIP Plus*, *HIP Basic*, or *HIP State Plan*). The HIP member uses the funds in their POWER Account to meet their $2,500 deductible. The MCEs are responsible for paying the claims for all covered services when the member's POWER Account is exhausted.

HIP Plus members, the state, employers, and other third parties may contribute to the POWER Account. POWER Accounts are designed to provide incentives for members to stay healthy, be value- and cost-conscious, and to use services in a cost-efficient manner, as well as to seek price and quality transparency. HIP members must be aware that prudent management of their healthcare expenditures can leave them with available POWER Account funds at the end of the annual benefit period, and that these funds can rollover to be used to lower the following year's contribution. The process for rollover is described in *HIP Plus Rollover* and *HIP Basic Rollover*.

Members enrolled in *HIP Plus* or *HIP State Plan Plus* are required to make contributions to their POWER Accounts. The household's PACs will be calculated based upon a tiered contribution structure established by the state. Notwithstanding the foregoing, the state will divide the monthly contribution between two HIP-eligible married adults, and each member is responsible for half of the calculated amount on a monthly basis.

Beneficiaries enrolled in *HIP Plus* will contribute to the POWER Account according to their income tier as described in Table 2:

Table 2 – POWER Account Tier Amounts*

Yearly Income	Monthly PAC Single Individual	Monthly PAC Spouses (each)
Up to and including 22% of the FPL	$1.00	$1.00
Above 22% of the FPL and up to and including 50% of the FPL	$5.00	$2.50
Above 50% of the FPL and up to and including 75% of the FPL	$10.00	$5.00
Above 75% of the FPL and up to and including 100% of the FPL	$15.00	$7.50
Above 100% of the FPL and up to and including 133% of the FPL	$20.00	$10.00
**Effective January 2019, members may be assessed a 50% tobacco use surcharge in addition to the POWER Account tier amounts.*		

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 make copayments which are assessed as one payment per type of service, per provider, per day. See *Covered Services* for a list of approved ACA and HIP preventive services that is to include dental and vision preventive services, when applicable.

Table 3 – HIP Basic and HIP State Plan Basic Copayments

Service	Copayment
Preventive Care (including Early Periodic Screening, Diagnostic, and Testing services and Family Planning services)	No copayment
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-Preferred Drugs	$8
Non-Emergent Emergency Department Use	$8 (except for individuals who call the MCE 24-hour nurse hotline before using the ED, for whom the copayment is then waived)

4.3 Member POWER Account Contributions

MCEs must bill for and collect member PAC payments for all *HIP Plus* and *HIP State Plan Plus* members. In no event should the MCE bill for or collect PACs from members who are pregnant, or members identified as an American Indian/Alaska Native (AI/AN). The state will identify all AI/AN members through the eligibility determination process. In addition, members who have reached their quarterly 5% maximum contribution limit should have their required PAC amounts reduced to the minimum of $1 for the remainder of the quarter.

The MCE receives the amount of the member's monthly PAC via the state's fiscal agent. The state will calculate the base PAC and the MCE must add any applicable surcharge. There is no penalty or fee for making payments through any of the payment processes, or for paying multiple months in advance.

Families may make combined POWER Account payments on behalf of each family member enrolled in the MCE's plan. This needs to be facilitated by the MCEs. MCEs will be able to apply a single payment with a single account number and will be able to determine how the member payment is to be applied.

When starting a new benefit period, member payments in the new benefit period cannot be applied to the oldest outstanding balance or member debt. For example, when a member makes a payment in month one of their new benefit period, but had missed their payment for month 12 of the previous benefit period, this payment shall be applied to the new benefit period.

Member payments in a new benefit period cannot be applied to past member debt. The difference between debt and past due balances is that members with debt have, at one point, dropped to *HIP Basic* or were terminated for failure to pay. Members are considered to have past due balances if they have not made their payments by the invoice date but are still within 60 days of the due date.

4.3.1 State POWER Account Funding

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. All member claims above $2,500 are the responsibility of the MCE.

The state will make an initial contribution of $1,300 to the POWER Account after the member receives full eligibility. POWER Account information is sent from the Indiana Eligibility Determination Services System (IEDSS) and promptly refers to the subsequent capitation cycle. state contributions must be credited to a member's POWER Account immediately upon receipt by the MCE from the state. At the conclusion of the member's calendar year benefit period, the MCE and the state shall reconcile the POWER Account in accordance with *POWER Account Reconciliation* procedures.

4.3.2 Employer POWER Account Payments

As a third-party entity, employers are permitted to contribute to members' POWER Accounts in the same manner as previously described and are encouraged to do so. The MCE must develop a program to publicize to members and employers that an employer may contribute to the member's POWER Account. Appropriate outreach materials must be developed, and the MCE must ensure that its member services staff can address calls from members and employers on this topic. Communications about employer contributions must be ongoing and continuous. The MCE must consider collecting the members' employment data during the health screening process or during other member outreach activities. The outreach materials for employers must identify the process the employer can use to contribute to employee POWER Accounts.

In addition to lump sum payments, employers are also allowed to make regular payments on a monthly basis toward their employee's required POWER Account contributions. When an employer fails to provide its share of a member's POWER Account contribution within 60 calendar days of its due date, the member will have an additional 60 calendar days to pay the overdue amount before being terminated from HIP if they are over 100% of the FPL. Members who are below 100% of the FPL will lose their *HIP Plus* coverage and drop to *HIP Basic* after the additional 60-day grace period if payment is not received.

4.4 Third-Party POWER Account Contributions

Third-party organizations are permitted to contribute to an individual's PAC. Third-party contributions must be credited to a member's POWER Account upon receipt.

To be eligible to contribute, third-party entities must continuously comply with the rules governing third-party contributions established in *405 IAC 10-10-4(d)*. Specifically, healthcare providers and provider-related entities are only permitted to contribute to a member's POWER Account if the provider or provider-related entity:

- Establishes criteria for providing assistance that does not distinguish between individuals based on whether they receive or will receive services from the contributing provider(s), and
- Does not include the cost of such payments in either the cost of care for purposes of Medicare and Medicaid costs reporting or included as part of a Medicaid shortfall or uncompensated care for any purposes.

MCEs should include this guidance in provider education materials and provider agreements. If the MCE learns of a healthcare provider or provider-related entity in violation of the previously described requirements, the MCE should report such payments to the state.

The MCE must also allow third-party entities to make lump-sum POWER Account payments. The MCE must ensure that lump-sum payments are credited to the member's required POWER Account contributions on a first month's basis. For example, for a member with a $10 per month PAC, if an employer or other third-party entity makes a one-time lump sum $50 contribution, then the MCE must credit the member's account and apply the payment to cover the immediately following five months of member's required PACs.

The MCE must keep record of all contributions made by third-party entities on behalf of members and make these records available to the state as outlined in the *MCE Reporting Manual* on the MCE Manuals page of the *MCE Secure Landing* page at in.gov/medicaid/partners.

4.5 Billing and Collection Services

Billing and collection services such as invoicing and payment methods are referenced in the following section. Each premium payment program is also referenced, followed by a detailed section for HIP POWER Account processing. Additional eligibility information for HIP is covered in *Member Enrollment*.

Premium billing and collection services include the following:

- Creating and maintaining *Health Insurance Portability and Accountability Act* (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 or POWER Account contribution refunds
- Transferring collected funds, as requested by the state
- Documenting and reconciling funds received and transferred

- Establishing and handling lockbox for HIP
- 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 healthcare industry standards, in addition to any Medicaid rules, regulations, or mandates, as well as amendments thereto
- Ensuring all mail is date-stamped on receipt
- Maintaining separate post office boxes, bank accounts, and reports for HIP
- Forwarding all change-of-address notifications and mail returned as undeliverable, as specified by the state

4.5.1 Fast Track Enrollment Billing and Collection

MCEs will receive Fast Track-eligible members and this Fast Track enrollment, billing, and collection section replaces the following standard enrollment process for applicants determined eligible for Fast Track enrollment by the state. Fast Track-eligible applicants are provided the opportunity to pay a $10 fee, called a Pre-POWER Account Contribution (PPAC), which, if paid, may result in an earlier enrollment month into the *HIP Plus* plan once an individual has been determined eligible by the state. The applicant may pay the PPAC at the time of application or following receipt of an invoice from the applicant's MCE.

HIP member eligibility shall not be final until either:

- The first day of the month in which the member pays an initial contribution to their POWER Account, or
- The first day of the month in which the initial 60-day 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 PPAC of $10 or their first month's POWER Account contribution in an amount determined by the state; however, the payment is due within 60 days of the initial Fast Track invoice. Members do not receive an additional 60 days to pay their POWER Account contribution from the date they are determined to be eligible (conditionally approved).

Enrollment month exceptions:

- American Indian/Alaska Native
- Pregnancy
- Members transferring from any other Medicaid aid category

For applicants who 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 the applicant's credit card payment. The MCE shall store the application ID number, payment amount, and payment date at least until the date the MCE is notified by the state of the applicant's final eligibility determination. The MCE shall receive pending eligibility files of individuals who selected, or who were auto-assigned to, their plan from the state and meet Fast Track eligibility criteria. The MCE shall review all pending eligibility files and identify applicants who have provided payment information to the MCE via the *Indiana Health Coverage Programs Application*. After the MCE

successfully verifies the payment, the MCE shall send the state notice of payment within one business day of receiving the pending eligibility file.

Within two business days of receiving the pending eligibility file of either:

- An applicant who did not pay the Fast Track payment via credit card on the *Indiana Health Coverage Application,* or
- Whose credit card information was unable to be successfully verified and/or processed, the MCE shall send an in initial invoice to the individual for a PPAC.

The invoice must include a notice explaining that the individual has not yet been determined eligible for HIP benefits, but that the initial Fast Track prepayment must be paid within 60 calendar days for the member to be eligible to receive *HIP Plus* benefits. The notice shall encourage prompt payment of the Fast Track prepayment, which could result in an earlier effective date for *HIP Plus* benefits.

The initial invoice must also include a prominent notice stating in substance that the individual has the right to select another MCE at any time before the first payment is made. After a payment is made, a member cannot change MCEs until MCE selection or with just cause. Such notice shall include information on how the individual 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:

- Will be fully refunded to the individual if the pending applicant is determined by the state not to be eligible for HIP, or
- Will be applied towards the member's future required PAC if the pending applicant is determined eligible for HIP.

The notice shall explain that if the member is determined eligible for HIP, their monthly PAC may be greater than the initial Fast Track prepayment, in which case, the member may owe more in the second month to continue to receive *HIP Plus* benefits.

A member's Fast Track prepayment or initial POWER Account contribution is due within 60 calendar days of the date the MCE receives on the member's pending eligibility file from the state. The MCE must provide at least two reminders during the 60-day payment period to individuals who have not made their initial Fast Track prepayment or first monthly PAC. Should the pending eligibility file be received less than 15 days before the payment period expires, such as when a member changes MCEs, the MCE may send only one reminder letter.

The MCE must process all payments and notify the state of the payment within 15 calendar days of receiving the payment. The 15-calendar day period allows time to ensure that payments made by check have cleared. Notwithstanding the foregoing, the MCE may elect to hold Fast Track prepayments received from applicants not yet determined eligible by the state until such time as the individual is determined eligible. If the MCE elects to hold such payments, then the MCE must verify the payment and notify the state of receipt of a valid payment method within 15 calendar days of receipt of the eligibility file. Receipt date is the day that the MCE received payment, not the day the MCE processes the payment. The MCE should populate the date paid using the receipt date of the payment, not the date the payment was processed. MCEs should see the "Pay File" section of the manual for details about timing and cut-off days for pay file submission. After the individual is determined eligible, the MCE must release the hold and process payment no later than 15 calendar days from the MCE's receipt of the eligibility file.

A pending applicant who is determined eligible for HIP by the state before the initial Fast Track prepayment is received and before the expiration of the 60-day payment period is considered conditionally eligible for HIP. A $10 Fast Track prepayment can be made at any time while the application is awaiting conditional approval. Within three business days of receiving the conditionally

eligible file, the MCE shall send a Welcome Letter to the conditionally eligible member. The *Welcome Letter* must be tailored to individuals at or below 100% FPL, and those above 100% FPL:

- The *Welcome Letter* to individuals above 100% FPL must explain that if the initial Fast Track prepayment or full POWER Account contribution is not received before the expiration of the 60-day Fast Track payment period, their coverage will not commence and they will have to reapply for HIP.

- The *Welcome Letter* to individuals at or below 100% FPL must explain that if the initial Fast Track prepayment or full POWER Account contribution is not received before the expiration of the 60-day Fast Track payment period, their coverage under *HIP Basic* begins on the first day of the month in which the payment period expires.

- The *Welcome Letter* to all conditionally eligible members who have not yet made a Fast Track prepayment must include a notice that if the member's POWER Account contribution is greater than $10, 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 is included on the subsequent month POWER Account invoice.

- The *Welcome Letter* must 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.

Because the MCE may collect the initial Fast Track prepayment before the member's individual POWER Account contribution has been determined by the state, the MCE is 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 MCE 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 per month contribution, the MCE must 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 MCE 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 invoice. The member shall have 60 calendar days to pay the remaining balance that includes the subsequent PAC.

For individuals who pay their Fast Track prepayment within the 60-day payment period but who are determined ineligible for HIP, the MCE shall return any such funds within 10 business days of the determination. The MCE will receive an FTE term 834 without a COND add 834.

4.5.2 Retroactive Prior Authorization for Fast Track Prepayments

Effective April 1, 2019, IHCP providers that assist certain individuals to complete an IHCP application and submit a Fast Track prepayment will be able to submit a prior authorization (PA) request for inpatient stays prior to the eligibility determination. If the individual is determined to be eligible for HIP, the provider is able to submit the PA request for services rendered since the first day of the month of the Fast Track prepayment if the individual is determined to be eligible for HIP.

This process applies to individuals who:

- Are 19 to 64 years of age

- Do not pursue temporary coverage through Presumptive Eligibility
- Submit an IHCP application with a Fast Track prepayment

Providers must use the following process for inpatient stays to ensure that they can properly submit a retroactive PA request for eligible individuals who submitted a Fast Track prepayment at the time of application:

1. The provider must assist an individual in completing an application for health coverage, including submitting a Fast Track prepayment.
2. Within 5 days of the date of admission, the provider must complete a *Fast Track Notification Form* (available on the Forms page at in.gov/medicaid/providers) and fax the form to the MCE selected on the application.
3. After eligibility has been established, the MCE will return a *Full Eligibility Notification Form* to the provider via fax within 7 days following eligibility discovery. This form will contain the member's MCE assignment and Member ID.
4. The provider will then be able to submit a PA request for the service rendered since the first day of the month of the Fast Track prepayment. Providers must submit the PA request within 60 days of receiving the Full Eligibility Notification Form from the MCE. Providers must verify eligibility, using the IHCP Provider Healthcare Portal, prior to submitting the PA request.

If an individual is not determined fully eligible within 60 days of the MCE receiving the *Fast Track Notification Form*, the MCE receiving the information will stop tracking the individual's eligibility status.

4.5.3 Standard Enrollment Billing and Collection

For HIP applicants who do not go through the Fast Track prepayment process, the MCE shall receive conditional eligibility files of individuals that selected or were auto-assigned to their plan from the state. Conditionally eligible members are reported to the MCE via the 834 enrollment transaction file – COND 834 add. The conditionally eligible PAC amount (monthly billing amount for the POWER Account contribution) is included in the transaction. See the *834 MCE Benefit Enrollment and Maintenance Transaction* companion guide. Within three business days of receiving the conditional eligibility file, the MCE shall send a *Welcome Letter* and initial invoice to the individual for their first PAC. The first invoice must reflect the member's monthly PAC as determined by the state. A conditionally eligible member's initial PAC is due within 60 days of the date the MCE receives the individual's 834 enrollment transaction file from the state.

The *Welcome Letter* must include a notice explaining that the individual must submit their initial payment within the 60-calendar-day payment period to receive *HIP Plus* benefits. The notice must be tailored to individuals at or below 100% FPL, and those above 100% FPL:

- The *Welcome Letter* to individuals above 100% FPL must explain that if the initial payment is not received within the 60-calendar-day payment period, their coverage will not commence and they will have to reapply for HIP.
- The *Welcome Letter* to individuals at or below 100% FPL must explain that if the initial payment is not received within the 60-calendar-day payment period, their coverage under *HIP Basic* begins on the first day of the month in which the 60-day payment period ends.
- The *Welcome Letter* must 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.

This notice must include specific information for how the individual may contact the enrollment broker by calling the toll-free HIP line to change MCEs.

As with all member communications, the *Welcome Letter* must be reviewed and approved by the state before distribution.

The MCE must provide at least two reminders within the 60-calendar-day period to individuals who have not made their first monthly PAC. If the conditional eligibility file is received less than 15 days before the payment period expires, the MCE may send only one reminder letter.

A conditionally eligible member's enrollment with the MCE begins on the first day of the month in which either:

- The first PAC is processed, or
- The nonpayment determination has been made for individuals at or below 100% FPL who do not make a PAC payment to be enrolled in *HIP Plus*.

The MCE must process all payments received from conditionally eligible members and notify the state of the payment within 15 calendar days of receiving the payment. The 15-calendar-day period allows time to ensure payments made by check have cleared.

Members identified as an American Indian/Alaska Native (AI/AN) pursuant to *42 CFR 136.12* are exempt from all cost-sharing and therefore such members' enrollment in the MCE's *HIP Plus* plan begins the first day of the month in which the individual applies for HIP. The MCE shall not bill members identified as AI/AN by the state.

4.5.4 Invoices

The MCE develops and mails invoices for HIP members that include the following information:

- The name of the MCE
- First name, last name, and address of payor
- First names of members
- Current monthly PAC owed
- Tobacco surcharge amount as a distinct addition to the PAC
- POWER Account contribution past due
- Overpayment shown as credit
- PAC due date
- Member identification (RID) number of the person responsible for payment
- Consequences of not paying the PAC
- Notice to send payment in all accepted forms, such as check, money order, online 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 MCE of an address change
- How to report any change in household or household income
- How to notify the MCE 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
- Information about a rollover credit, if applicable
- Any additional information as directed by the FSSA

Regardless of whether the MCE subcontracts the billing and collections function to another entity, invoices and any other related billing and collections materials must be sent under the MCE's name, not the name of the subcontractor.

The MCE must translate invoices into the language specified by the member or the member's family. At this time, the state notifies the MCE via the 834 transaction if a member's primary language is Spanish. At this time, there are no additional languages identified and provided to the MCEs.

At a minimum, the invoice mailing must include an invoice with a detachable invoice payment slip and a return pre-paid postage envelope. Occasional one-page inserts may be required by the state to explain program or billing changes. The MCE must also provide members the option to sign up for and receive invoices via email.

4.5.5 POWER Account Procedures for Collecting HIP Plus Member Contributions

The following are step-by-step procedures for collecting member POWER Account contributions. Member POWER Account contributions are monthly. MCEs must send invoices to members detailing the amount due each month. The monthly invoice amounts are calculated by the state and provided to the MCE via the 834 enrollment transaction. The MCE is required to calculate and include any surcharges or discounts on the member invoice. The monthly invoice must include the monthly amount to be paid and must provide members with reasonable notice of the upcoming due date.

If applicable, MCEs must allow families with more than one family member enrolled in their plan to make combined payments on behalf of all family members. Members are required to clearly indicate that the payment is for multiple accounts, to which accounts the payment applies, and how the funds are to be distributed. MCEs must provide instruction to members about how to provide payment for multiple accounts.

MCEs must provide all the following options for making member POWER Account contributions:

- Check
- Money order
- Automatic payroll deduction
- Employer withholding (after taxes)
- Credit card
- Cash (including cash payments by mail, although this option does not need to be promoted to members as a payment option)
- Online payment via web portal
- Unlimited electronic check or debit card payment via telephone
- Automatic draft withdrawal from a designated account
- Automated Clearinghouse (ACH)
- Electronic funds transfer

The cash payment process must be available through a statewide network of banks or other entities. The MCE should seek arrangements with local entities to facilitate the collection of contributions, particularly no-cost options for collecting cash contributions. To assist the MCEs in the development of their statewide network of entities for cash contributions, the state has identified Walmart as a potential vendor for no-cost cash contributions. The MCEs are expected to use commercially reasonable efforts to contract with Walmart (and other potential vendors identified by the state) to implement a statewide solution for the collection of cash contributions at no cost to the member. The MCE must ensure that any cash contributions collected by third-party vendors are credited toward the member's POWER Account within two business days.

When a member has multiple employers, the MCE is required to provide the payroll deduction option for only one of the member's employers at any given time. For example, if the member changes employers, the member must be permitted to make payments via payroll deduction with the new employer; however, if a person has multiple jobs, the MCE is required to accept payment from only one employer via payroll deduction.

HIP members must be allowed to pay more than their monthly contributions, up to the total amount of their monthly PACs for the year, at any time without penalty. Although additional payments may fully offset future billing, the MCE must continue to send monthly invoices reflecting the amount due and credits on the account.

MCEs must deposit checks no later than 24 hours from receipt. An MCE's member education materials must inform members of the available options for making POWER Account contribution payments. If a member's check is returned because of insufficient funds, the plan may charge members a reasonable fee for the returned check. If an MCE receives a check improperly made out to the state or the fiscal agent, the plan must follow up with the member and instruct the member to make the check payable to the plan.

There are occasions that the state receives a money order from a member. In these cases, the member is not required to send a new money order. In these instances, the state wants to work with the member and the MCE, and the MCE will need to apply the credit to the member's account. This can be done through the state's Customer Satisfaction Team (CST).

4.5.6 Ongoing Billing and Collections

The MCE must bill for, and collect, PACs on a monthly basis. Partial monthly payments may be accepted by the MCE; however, the member must pay the monthly payments missed in full within 60 days from the first day of the coverage month for which the first POWER Account contribution was missed.

The MCE must create a system to encourage members to make their PACs and track those members who are late with payment. The system must include member education, outreach, and reminders. Member education and outreach efforts should be included in new member materials and coordinated with any communication the MCE makes with new members for health screenings, risk assessments, and primary medical provider selections.

The MCE must notify members when the member fails to make a PAC payment by the due date. The MCE must provide at least two written notices of the delinquent payment as a payment reminder. The first such reminder must be sent on or before the seventh calendar day of non-payment. The reminders must include the following information:

- The date by which the contribution must be paid to prevent application of the non-payment penalty, which includes member termination for individuals over 100% FPL or transfer to *HIP Basic* benefits for individuals at or below 100% FPL.

- An explanation of the nonpayment policies, including information on how the member may request a screening for a medically frail determination.
- For individuals 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 individual's appeal rights.
- For individuals over 100% FPL, a reminder that if the member is terminated from HIP for nonpayment the member's portion of their POWER Account balance is subject to a 25% penalty.
- For individuals at or below 100% FPL, a reminder that if the member is transferred to *HIP Basic*, a reminder that the member will have a reduction in benefits and potentially increased cost-sharing through required copayments for all services, and that the member may not return to *HIP Plus* benefits until the member's redetermination or rollover process occurs, and that any remaining balance in member contributions is subject to a 25% penalty.
- An explanation of the member's appeal rights.
- Information regarding how to report any change in household or household income.
- A member helpline telephone number for the member to call if they have any questions.

4.6 Nonpayment of Initial and On-Going POWER Account Contributions

A payment made by check that is dishonored because of nonsufficient funds (NSF) is considered nonpayment. Members who make such payments must provide the full PAC that is in delinquency within 60 calendar days of its original due date. The MCE may charge a reasonable fee for an NSF check. The MCE must develop, print, and mail notices to members if members' payments are returned from the bank because of NSF.

If a member has not paid their missed PAC within 60 calendar days of due date, the MCE must notify the Indiana Eligibility Determination Services System (IEDSS) through Core Medicaid Management Information System (*Core*MMIS). This notification must be sent electronically to the state via the fiscal agent, by the monthly adverse action date. Adverse action dates vary each month.

4.6.1 Conditionally Eligible Members

Conditional members are reported to the fiscal agent, currently Gainwell, using the HIP Daily Pay/No Pay files. The fiscal agent passes the pay or nonpayment notification to IEDSS daily for conditional members. An email from DSIB Prod is generated to the MCE if an error is detected that includes the error type/response. Any records not posted to the fiscal agent by 4 p.m. or rejected for errors will not be processed.

4.6.2 Members Below 100% Federal Poverty Level

Conditionally eligible *HIP Plus*/*HIP State Plan Plus* members who do not make an initial Fast Track prepayment before the expiration of the 60-calendar day Fast Track payment period or do not make required POWER Account contribution payment within 60 calendar days of due date will be enrolled into *HIP Basic/HIP State Plan Basic.*

If a No Pay file is sent on a conditionally eligible *HIP Plus*/*HIP State Plan Plus* member, the member will be enrolled into *HIP Basic*/*HIP State Plan Basic* the month the file is received in IEDSS. IEDSS notifies the fiscal agent via the CDEE file and *Core*MMIS generates an 834 record to the MCE with the updated eligibility and aid category. MCE will receive a conditional 834 term and a fully eligible 834 add for *HIP Basic/HIP State Plan Basic*. Members who are enrolled in *HIP Basic/HIP State Plan Basic* will have a POWER Account that is fully funded by the state. The member will be incentivized to use the POWER Account properly like a *HIP Plus/HIP State Plan Plus* member with the possibility of rollover if there are remaining funds at the end of the benefit period.

4.6.3 Members Above 100% Federal Poverty Level

Except for members that are medically frail, conditionally eligible *HIP Plus*/*HIP State Plan Plus* members who do not make an initial Fast Track prepayment before the expiration of the 60-calendar day Fast Track payment period or do not make required POWER Account contribution payment within 60 calendar days of due date will be terminated and need to reapply.

If a No-pay file is sent on a conditionally eligible *HIP Plus*/*HIP State Plan Plus* member who is neither medically frail nor receiving transitional medical assistance (TMA), their eligibility will be terminated the day the file is received by IEDSS. IEDSS notifies the fiscal agent via the CDEE file and *Core*MMIS generates an 834 record to the MCE with the updated eligibility and aid category. The MCE will receive a conditional 834 term.

If a No-pay file is sent on a conditionally eligible *HIP State Plan Plus* member who is medically frail, they will be enrolled in *HIP State Plan Plus* with copays (MA PC) the month the file is received in IEDSS. IEDSS notifies the fiscal agent via the CDEE file and *Core*MMIS generates an 834 record to the MCE with the updated eligibility and aid category. The MCE will receive a conditional 834 term and a fully eligible 834 add for *HIP State Plan Plus* but with copayments (MA PC). Such medically frail members will receive *HIP State Plan Plus* benefits but are required to pay copayments for services consistent with the *HIP State Plan Basic* copayments. In addition, the MCE will continue to send monthly POWER Account invoices and the member will continue to incur debt to the MCE for any unpaid PAC amounts. Members in the *HIP State Plan Plus* copays category (MA PC) may only regain access to traditional *HIP State Plan Plus* benefits without copays at their annual redetermination or rollover, regardless of whether the member becomes current on their PAC payments during the remainder of their eligibility period.

4.6.4 Fully Eligible/On-Going Plus Members

Fully eligible members are reported on the HIP Weekly/Monthly No Pay files. The fiscal agent passes the nonpayment notification to IEDSS once a month for fully eligible members. An email from DSIB Prod is generated to the MCE if an error is detected that includes the error type/response. Any records not posted to the fiscal agent by 4 p.m. or rejected for errors will not be processed.

4.6.4.1 Members Below 100% Federal Poverty Level

Fully eligible *HIP Plus*/*HIP State Plan Plus* members who do not make their on-going required POWER Account contribution payment within 60 calendar days of due date will be transferred into *HIP Basic/HIP State Plan Basic.*

If a No Pay file is sent on a fully eligible *HIP Plus*/*HIP State Plan Plus* member, the member will be transferred into *HIP Basic*/*HIP State Plan Basic* the following month the file is received in IEDSS (could be pushed out later due to adverse action date). IEDSS notifies the fiscal agent via the CDEE file and *Core*MMIS generates an 834 record to the MCE with the updated eligibility and aid category. MCE will receive a fully eligible 834 change record from *HIP Plus* to *HIP Basic*. Members who are

enrolled in *HIP Basic/HIP State Plan Basic* will have a POWER Account that is fully funded by the state. The member will be incentivized to use the POWER Account properly like a *HIP Plus/HIP State Plan Plus* member with the possibility of rollover if there are remaining funds at the end of the benefit period.

4.6.4.2 Members Above 100% Federal Poverty Level

Except for members that are medically frail, fully eligible *HIP Plus*/*HIP State Plan Plus* members who do not make their on-going required POWER Account contribution payment within 60 calendar days of due date will be terminated.

If a No-pay file is sent on a fully eligible *HIP Plus*/*HIP State Plan Plus* member who is neither medically frail nor receiving TMA, they will be terminated at the end of the month the file is received in IEDSS. IEDSS notifies the fiscal agent via the CDEE file and *Core*MMIS generates an 834 record to the MCE with the updated eligibility and aid category. The MCE will receive a conditional 834 term.

If a No-pay file is sent on a fully eligible *HIP State Plan Plus* member who is medically frail, they will remain enrolled in *HIP State Plan Plus* but with copays (MAPC) the following month the file is received in IEDSS. IEDSS notifies the fiscal agent via the CDEE file and *Core*MMIS generates an 834 record to the MCE with the updated eligibility and aid category. The MCE will receive a fully eligible 834 change record. Such medically frail members will receive *HIP State Plan Plus* benefits but are required to pay copayments for services consistent with the *HIP State Plan Basic* copayments. In addition, the MCE will continue to send monthly POWER Account invoices and the member will continue to incur debt to the MCE for any unpaid PAC amounts. Members in the *HIP State Plan Plus* copays category (MAPC) may only regain access to traditional *HIP State Plan Plus* benefits without copays at their annual redetermination or rollover, regardless of whether the member becomes current on their PAC payments during the remainder of their eligibility period.

If a No-pay file is sent on a fully eligible *HIP State Plan Plus* member who is receiving TMA, they will remain enrolled in *HIP State Plan Plus* for six months. Once a No-Pay is sent in the seventh month, the member's eligibility will be terminated at the end of the month the file is received by IEDSS. IEDSS notifies the fiscal agent via the CDEE file and *Core*MMIS generates an 834 record to the MCE with the updated eligibility and aid category. The MCE will receive a fully eligible 834 termination record.

4.6.5 Fully Eligible Basic Potential Plus (Basic+)

The *Potential Plus* designation allows a member to open with *HIP Basic/HIP State Plan Basic* coverage or maintain *HIP Basic/HIP State Plan Basic* coverage while allowing them a 60-day period to pay a POWER Account contribution to buy up to *Plus*. Members are given a *HIP Basic/HIP State Plan Basic with Potential Plus* (also referred to as *Basic+*) designation when they transition from an IHCP program into the HIP program (such as a member moving from Hoosier Healthwise or Hoosier Care Connect into HIP). This can also apply to members who are moving from the Hospital PE or PE programs, members who are moving from an incarcerated suspended status to HIP, *HIP Basic* members who have an income increase that moves them over 100% FPL, and *HIP Basic* members that earn *Potential Plus* as part of the rollover process.

Members transitioning from non-HIP categories to HIP, such as CHIP members or pregnant women, will go *Basic+* for 60 days to provide a timeframe for the member to make a payment without a gap in coverage.

If a *HIP Basic* or *HIP State Plan Basic* member reports a change in income or family size that increases their income over 100% FPL, the state will notify the MCE of the change via the 834

transaction. The member is identified as *Basic+*. The MCE is required to begin billing the member and the member has 60 days to make a payment. If payment is received, the member is transferred to *HIP Plus* or *HIP State Plan Plus.* Member income increases are an appealable action.

4.6.5.1 Members Below 100% Federal Poverty Level

If a No-pay file is sent on a fully eligible *HIP Basic+* or *HIP State Plan Basic+* member, the member will remain enrolled in *HIP Basic* or *HIP State Plan Basic* but lose the *Potential Plus*.

4.6.5.2 Members Above 100% Federal Poverty Level

If a No-pay file is sent on a fully eligible *HIP Basic+* or *HIP State Plan Basic+* member who is not medically frail, the member's eligibility will be terminated.

If a No-pay file is sent on a fully eligible *HIP Basic+* or *HIP State Plan Basic+* who is medically frail, the member will transfer to *HIP State Plan Plus* with copayments (MA PC).

4.7 POWER Account Contribution Recalculations

A member must report all changes to the state that may affect eligibility and POWER Account contributions, including changes in income or family size, such as death, divorce, birth, or family member moving out of the household. The MCE must notify members of how to report a change in income or family size, and explain that, as described in their initial eligibility letter from the Division of Family Resources (DFR), the member is responsible for notifying the state about changes in income and family size via the *Change Report Form*.

The state notifies the MCE when a member's POWER Account contribution amount changes via the 834 transaction. Additional information on the 834 transaction is available on the *MCE Secure Landing* page at in.gov/medicaid/partners under *MCE Manuals* and in the *834 MCE Benefit Enrollment and Maintenance Transaction* companion guide. The MCE must begin billing the new POWER Account contribution or premium amount in the billing cycle immediately following the change. For example, in June, the member has a premium amount of $20. In July, the member loses their job and requests a recalculation through the DFR. The CDEE file is sent to *Core*MMIS and *Core*MMIS generates an 834 change record that notifies the MCE in August that the member's new POWER Account contribution is $10. The MCE bills the member for the new POWER Account contribution in September.

The PAC is a monthly amount. Recalculations could result in the member being paid in advance or having a higher contribution amount.

Section 5 Personal Wellness and Responsibility (POWER) Accounts

5.1 Use of POWER Account Funds

Each member is responsible for the use of funds in their POWER Account until the deductible is met. POWER Account funds can be used by the member only to pay for HIP covered services. See *Covered Benefits and Services* for a list of the HIP covered services.

In spending POWER Account funds, members must be permitted to apply these funds to the following covered services, even if obtained through out-of-network providers:

1. Family planning services, if obtained from an IHCP provider
2. Emergency medical services
3. Other self-referral services, if obtained from an IHCP provider
4. Medically necessary covered services, if the MCE'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)* and *Section 5.14*.
5. Nurse practitioner services, if provided by an IHCP provider

Members cannot use POWER Account funds to pay for the emergency department services copayment described in *Covered Benefits and Services*.

Members enrolled in *HIP Basic* or *HIP State Plan Basic* cannot use POWER Account funds to pay for any plan-required copayments.

5.2 POWER Account Balance Information

The MCE must maintain up-to-date member POWER Account balance information. This information must be mailed to members on a monthly basis in the form of a POWER Account statement. It must also be available online via a secure member portal. The information must reflect real-time changes in the member's POWER Account, as evidenced by paid claims. It must also indicate the member's monthly contribution amounts and the state's contribution amount.

POWER Account balance information must also be available to members by contacting the MCE's member helpline. The MCE must give members an opportunity to receive email 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 MCE may combine it with the explanation of benefits (EOB) information required in this manual.

5.2.1 Directed Payment for Eligible Out-of-State Children's Hospitals

In accordance with House Enrolled Act (HEA) 1305, 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. The HIP program requires the MCE reimburse at the state-directed minimum fee schedule established by the state.

Therefore, the HIP directed payment supersedes. The MCE should pay the out-of-state children's hospitals using the HIP reimbursement methodology.

The IHCP has identified the following out-of-state Children's hospitals that are eligible to receive reimbursement under HEA 1305:

Hospital Name	LPI	NPI
Advocate Children's Hospital	300011814	1508315516
Ann & Robert Lurie Children's Hospital	300012683	1235234535
Children's Hospital of Michigan	300042834	1538471800
Cincinnati Children's Hospital Medical Center	100069650A	1548212988
Dayton Children's Hospital	300020322 300037420	1457379448
La Rabida Children's Hospital	100275950A	1427146430
Nationwide Children's Hospital	100069780A	1134152986
Norton Children's Hospital	100069740A	1982609442
Norton Women's & Children's Hospital	100034170A	1831195908
Shriners Hospitals for Children (Chicago)	201076690A	1376656538
Shriners Hospitals for Children (Cincinnati)	201065990A	Facility Closed
University of Chicago - Comer's Children's	201065990B	1659590644

5.3 Interest

Neither members nor the MCE may retain interest on POWER Accounts. The MCE must keep POWER Account funds in a hard interest-bearing deposit account that will earn the bank's prevailing interest rate. The funds shall be kept in a separate account and never comingled. The MCE must 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 MCE must report in the aggregate the interest accrued on its members' POWER Accounts. The MCE must 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.

5.4 Audit Requirement

The MCE must engage an external entity to conduct an annual audit of its POWER Account operations and administration and provide these results to the state.

5.5 Rollover

At the end of the benefit period, members have an opportunity for any funds remaining in the member's Personal Wellness and Responsibility (POWER) Account to be rolled over and applied as a credit toward the member's required Power Account contribution (PAC) in the subsequent benefit period. The amount rolled over or discounted, as applicable, depends on whether the member received their recommended preventive care services, and what program (*HIP Plus* or *HIP Basic*) the member is enrolled in on the last day of their benefit period before the benefit period in which rollover is being calculated for and applied. To allow a claims run-out period, rollover must occur 121 calendar days following the end of the benefit period.

When performing the rollover function, the managed care entity (MCE) must comply with the rollover procedures in this manual. The MCE must have the capability to transmit the required rollover data electronically.

After a 121-calendar day reconciliation period following the end of the benefit period, the MCE must report any rollover amounts or discounts to the state fiscal agent on the POWER Account reconciliation file (PRF). The MCE must notify members of any rollover amounts and/or discounts, as well as any changes in their monthly PAC amount because of rollover. If a member has sufficient rollover dollars (state and member) to cover one month's PAC, then the MCE will use *HIP Plus* rollover amount as a credit on the account. If a *HIP Basic* or *HIP State Plan Basic* member is eligible for a discount for participation in *HIP Plus*, then the MCE must notify the member of the opportunity to transfer to *HIP Plus* benefits or *HIP State Plan Plus* at the discounted rate.

The amount of leftover and available funds rolled over or discounts applied to current year PACs, as applicable, depend on the following:

- The member's contributions to the POWER Account
- The balance remaining in the member's POWER Account
- Any member debt
- The member's receipt of recommended preventive care services
- Which program (*HIP Plus* or *HIP Basic*) the member is enrolled in on the last day of the rollover benefit period before the current benefit period in which rollover is being applied

Because each individual enrolled in HIP has a separate POWER Account, family size does not impact the POWER Account rollover.

Except for initial payments into *HIP Plus*/*HIP State Plan Plus*, when PACs fall under $1.00 because of rollover, MCEs can choose whether to bill the member or to adjust off the member balance due.

5.6 POWER Account Reconciliation File Timing – Rollover

On day 30 after the end of the rollover calendar year benefit period, the MCE for the rollover benefit period sends Gainwell an initial rollover (IR) PRF to include member rollover dollars, state rollover dollars, and discount amount, dependent on if member received preventive services. Gainwell receives inbound PRF from MCE with prior benefit period. If the file is successful, then Gainwell sends PRF outbound to MCE for the current BP. Gainwell sends the response file indicating that the data was valid before the outbound PRF is generated. On day 31, Gainwell sends PRF out to the MCE.

At 121 calendar days after the end of the HIP calendar year benefit period, the MCE sends a final rollover (FR) PRF to Gainwell with all the final data elements (claims, preventive services, and debt), this is the FR record type. Gainwell generates outbound PRF. Gainwell sends the data on a supplemental file to the Indiana Eligibility Determination Services System (IEDSS) and IEDSS sends response file.

Depending on type of rollover the member earned (based on status at the end of the prior benefit period) determines if a change record needs to be processed.

If member is *HIP Plus* but earned *HIP Basic* discount (prior benefit period as a *HIP Basic* member) – 834 001 change record. Rollover dates need to be aligned with what is sent by IEDSS reflecting PAC adjustments for previous *HIP Plus* segment.

If the member is *HIP Basic with Potential Plus*, the rollover expires after 60 days. The application of the *Potential Plus* rollover on the HIP pay file should occur the last Friday of each month following the reconciliation of the POWER Account.

Should the pay file not be sent by the last Friday of each month following the reconciliation of the POWER Account or before the rollover expiration because of error, those cases will be sent to the Customer Service Team (CST) to review and take action as determined applicable.

If a member earned a state discount (can be *HIP Plus* or *HIP Basic* at the time of reconciliation), then member dollars are transferred on the PRF with state rollover dollars and no pay record is sent. If a member is currently *HIP Basic* and earned a *HIP Basic* discount, then they will receive a *HIP Potential Plus* loop and that is on the 834 (Gainwell to MCE). State Discount Percentage is reported on the PRF and should be in the format of a whole number with no decimals.

Rollover should be identifiable on and applied to the member's invoice the month following the receipt of the 820 from the POWER Account reconciliation capitation process.

All rollover PRF transactions must be successfully processed following the timeline provided by OMPP.

5.7 Member Rollover Dollars

Regardless of the member's benefit plan or use of preventive services, the member dollars in the account always roll over to the next benefit year, unless the member has made an overpayment in the current year. Current year overpayments must be refunded to the member. Applying rollover to an account may cause the member to have overpaid in the current year, depending on how much they rolled over and paid before rollover being applied. Member dollars may roll over even if the dollars rolling over to the next year are more than the member's required contribution for the next year. Prior year rollover does not roll over to the next year and any remaining rollover should be refunded to the member.

Member rollover can never be more than $240 in a calendar year benefit period and $360 for members with a tobacco surcharge. The maximum amount of member rollover allowed on the rollover (IR/FR) or rollover transfer (IX/FX) PRF submission is $240 and the rest will be refunded to the member as a current year overpayment.

5.7.1 Calculating Rollover

Rollover is calculated 121 days after the end of the calendar year benefit period. Members may have enrolled and non-enrolled months during the calendar year. A member's rollover is based on their enrolled months. Any member dollars remaining from a prior year's rollover when processing an account termination should be refunded to the member.

- Calculation of a member's rollover amount will always be based on the member's actual contributions to their PAC. Claims payment allocation from a POWER Account should always be based on the member's payment in the PAC during the calendar year. Any member rollover dollars in excess of the member's required contribution are not taken into account when calculating the current year's rollover amount, state matching dollars, or when calculating the member percent of claims owed.

- Members that complete preventive services may be eligible for state matching dollars to further reduce or eliminate their contribution. State matching dollars cannot be more than the member's total contribution and state match earned in a prior year does not roll over into the next year.

- Member rollover is always applied to owed balances first, followed by state matching dollars, up to the total amount of the member's contribution for the calendar year. Unused state matching dollars are lost to the member and returned to the state at year-end during account reconciliation. Unused member

rollover for that year remains the member's money and will be refunded to the member as a current year overpayment. Members that terminate may be refunded remaining member rollover dollars.

- Member dollars and state matching dollars for rollover are applied as a credit on the member account. These credits can be used pay the member's PACs until they have been expended.

- The maximum amount of member rollover allowed on the rollover (IR/FR) or rollover transfer (IX/FX) PRF submission is $240 and the rest will be refunded to the member as a current year overpayment.

- When a percent discount is applied, *HIP Basic* members only receive the percent discount on months of *HIP Plus* coverage following the rollover calculation.

- When a *HIP Basic* member discount is being applied, *HIP Plus* members have the discount applied retroactively to their entire enrollment period as a *HIP Plus* member, not just prospectively. Members can receive discounts on PAC already paid in current year when rollover is applied. This should create a credit on the account.

- *HIP Basic* members that have member contributions or rollover from a prior *HIP Plus* enrollment have these contributions carried forward and applied to their *HIP Potential Plus* required contribution amount. The contributions rolled over have the 25% penalty amount applied to them. *HIP Basic* members can qualify for this rollover even if they did not have preventive care and will receive a *HIP Potential Plus* segment when there are member dollars to apply, regardless of if they qualify for *HIP Basic* percentage discount rollover.

- *HIP Basic* members with member dollar rollover receive a credit on their account for their *HIP Potential Plus* segment. Members with enough member dollar rollover to cover at least one month of PAC should have a pay file sent the last Friday of the month following the reconciliation and should be moved to *HIP Plus*. If the amount is not enough to cover one month's PAC, the MCE is required to bill the rest of the contribution.

- Members may have both dollars and percentage rollover. The discount is applied first and then the credits are applied to the remaining balance.

- Even if member and state rollover amounts are more than the member's current estimated PAC amount for the year, the full amount is counted as rollover. The member may benefit from this rollover if they have a future PAC increase.

- When a member terminates, any member dollars from rollover are refunded to the member following the completion of the calendar year. These dollars are subject to the 25% penalty as applicable.

- For members who are terminated when rollover is calculated, the rollover information is still processed and applied to the account for the next calendar year enrollment. The member's subsequent year account will be reconciled following the end of the calendar year. Members may be refunded any pre-payments for months in which they were not enrolled. Refund of member rollover would occur on account reconciliation.

- Member debt may be collected from member rollover. Any current year past due balances are reconciled prior to calculating rollover; prior year's debt would be subtracted from member rollover dollars after state matching dollars are calculated. Member debt cannot be subtracted from state matching rollover dollars.

- Members that are pregnant in the HIP MAMA category receive rollover like a *HIP Basic* member, and the discount is held until the member returns to *HIP Basic* after the conclusion of their pregnancy. Rollover for MAMA members never apply the 25% penalty.

- 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.

Rollover information is sent to the MCE with the subsequent HIP benefit period, even if the member has terminated at the time rollover is being processed. The member's subsequent year account will be reconciled after accounting for rollover and the member will receive any refund owed. The rollover process will vary for *HIP Plus* and *HIP Basic*.

5.7.2 Rollover Scenarios

The following tables describe the HIP POWER Account rollover scenarios.

Table 4 – Scenario 1: Rollover for a *HIP Plus* member who does not qualify for state match

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$60	$32
Total Dollars Paid by Member	$100	$40	$68
Total Member PAC Paid *(Rollover + Member $)*	$100	$100	$100
Member PAC Owed	$100	$100	$100
Member Final Account Balance	$1,500	$800	$2,500
Member Dollars Remaining/ Member Rollover Earned for Following CY	$100 x ($1,500/$2,500) = $60	$100 x ($800/$2,500) = $32	$100 x ($2,500/$2,500) = $100
State Matching Rollover Dollars	N/A	N/A	N/A
Member Discount Percentage	N/A	N/A	N/A
Member overpayment refund amount			
Notes:	• *Member receives $60 of rollover. Rollover is applied to CY 2 after the PRF reconciliation of CY 1. Member did not get preventive services, so no state rollover (match) is earned.* • *Member receives $32 of rollover. Rollover is applied to CY 3 after the PRF reconciliation of CY 2. Member did not get preventive services, so no state rollover (match) is earned.*		

Table 5 – Scenario 2: Rollover for a *HIP Plus* member who does qualify for state match

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$60 member + $40 state	$32 member + $32 state
Total Dollars Paid by Member	$100	$0	$36
Total Member PAC Paid *(Rollover + Member $)*	$100	$100	$100
Member PAC Owed	$100	$100	$100
Member Final Account Balance	$1,500	$800	$2,500
Member Dollars Remaining/ Member Rollover Earned for Following CY	$100 x ($1,500/$2,500) = $60	$100 x ($800/$2,500) = $32	$100 x ($2,500/$2,500) = $100
State Matching Rollover Dollars	$60	$32	$100
Member Discount Percentage	N/A	N/A	N/A
Member overpayment refund amount	N/A	Any funds the member paid towards their PAC since covered by rollover.	
Notes:	• *Member receives $120 of rollover ($60 member and $60 state match) for CY 2. Rollover is applied after the PRF reconciliation of CY 1. The $60 member rollover is applied first. $40 of State rollover is then applied to cover the remaining balance. The remaining $20 of State rollover returns to the State when the CY 2 account is reconciled.* • *Member dollars paid in CY 2 are refunded as member had enough rollover to cover entire year's PAC.* • *Member receives $64 of rollover for CY 3. Rollover is applied after the PRF reconciliation of CY 2.*		

Table 6 – Scenario 3: *HIP Plus* member with state match and excess member rollover in year 2

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$12	$3.84 member + $3.84 state
Total Dollars Paid by Member	$100	$0	$92.32
Total Member PAC Paid *(Rollover + Member $)*	$100	$12	$100
Member PAC Owed	$100	$12	$100
Member Final Account Balance	$1,500	$800	$2,500
Member Dollars Remaining/ Member Rollover Earned for Following CY	$100 x ($1,500/$2,500) = $60	$12 x ($800/$2,500) = $3.84	$100 x ($2,500/$2,500) = $100
State Matching Rollover Dollars	$60	$3.84	$100
Member Discount Percentage	N/A	N/A	N/A
Member overpayment refund amount	N/A	Any funds the member paid towards their PAC since covered by rollover.	If member paid in more than $92.32 ($100-$7.68) for the year, then the excess is refunded.
Notes:	• *Member receives $120 of rollover ($60 member and $60 state). Rollover is applied after the PRF reconciliation of CY 1.* • *$12 Member rollover is applied first for CY 2. Member is refunded the remaining $48 of member rollover as current year overpayment.* • *Member does not need State CY1 rollover dollars, so the $60 State rollover returns to the State when the CY2 account is reconciled.* • *Member dollars paid in CY 2 are refunded as member had enough rollover to cover entire year's PAC.*		

Table 7 – Scenario 4: *HIP Plus* member who does not qualify for state match and has excess member rollover in year 2 who terminates

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$12	$3.84 member + $3.84 state
Total Dollars Paid by Member	$100	$0	$92.32
Total Member PAC Paid *(Rollover + Member $)*	$100	$12	$100
Member PAC Owed	$100	$12	$100
Member Final Account Balance	$1,500	$800	$2,500
Member Dollars Remaining/ Member Rollover Earned for Following CY	$100 x ($1,500/$2,500) = $60	$12 x ($800/$2,500) = $3.84	$100 x ($2,500/$2,500) = $100
State Matching Rollover Dollars	N/A	N/A	N/A
Member Discount Percentage	N/A	N/A	N/A
Member overpayment refund amount	N/A	$3.84 remaining member dollars + $48.00 excess rollover + any current year overpayment (a 25% penalty will be applied where required).	If member paid in more than $92.32 ($100-$7.68) for the year, then the excess is refunded.
Notes:	• *Member receives $60 of member rollover. Rollover is applied after the PRF reconciliation of CY 1. Member did not get preventive services so no state rollover (match) is earned.* • *$12 Member rollover is applied for CY 2. Member terminates in year 2.* • *Member is refunded $3.84 of current year contribution.* • *Member is refunded $48.00 of excess rollover.* • *If the Member paid any PAC in current year, this is refunded as member had enough rollover to cover entire year's PAC and the member terminated.* • *If the termination is a penalty reason member has a 25% penalty applied to all refunds.*		

Table 8 – Scenario 5: Rollover for a *HIP Basic* member that bought up to *HIP Plus* in year 2, member stays in *HIP Plus* in year 3

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$0	$16 member + $16 state
Total Dollars Paid by Member	$0	$50	$68

Total Member PAC Paid *(Rollover + Member $)*	$0	$50	$100
Member PAC Owed	$0	$100 x 50% discount = $50	$100
Member Final Account Balance	$1,500	$800	$2,500
Member Dollars Remaining/ Member Rollover Earned for Following CY	N/A	$50 x ($800/$2,500) = $16	$100 x ($2,500/$2,500) = $100
State Matching Rollover Dollars	N/A	$16	$100
Member Discount Percentage	$1,500/$2,500 = 60%	N/A	N/A
Member overpayment refund amount	N/A	Any funds the member paid above $50 would be refunded.	If the Member paid more than $68 PAC in current year, this is refunded as a current year overpayment.
Notes:	• *Member bought up to HIP Plus and receives a 50% discount on PAC for the entire period (calendar year 2) of HIP Plus enrollment including months preceding application of rollover.* • *If member owed $100 for the year and paid in $40 by the time they get rollover applied, the 50% discount should reduce the yearly PAC amount to $50. Member should only owe $10 for the remainder of the calendar year.* • *Member receives $16 of member rollover. Member received preventive services, so this is matched by $16 of state rollover. Rollover is applied at the start of May following conclusion of calendar year 2.* • *For CY 3, the member is responsible for the remain $68 of PAC after rollover is applied.* • *If the Member paid more than $68 PAC for CY 3, this is refunded as a current year overpayment.*		

Table 9 – Scenario 6: *HIP Plus* member that has excess dollars paid in current year and receives a current year refund. Member receives preventive care

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$60 member + $40 state	$32 member + $32 state
Total Dollars Paid by Member	$100	$30	$36
Total Member PAC Paid *(Rollover + Member $)*	$100	$100	$100
Member PAC Owed	$100	$100	$100
Member Final Account Balance	$1,500	$800	$2,500
Member Dollars Remaining/ Member Rollover Earned for Following CY	$60	$100 x ($800/$2,500) = $32	$100 x ($2,500/$2,500) = $100
State Matching Rollover Dollars	$60	$32	$100
Member Discount Percentage	N/A	N/A	N/A
Member overpayment refund amount	N/A	$30	If the Member paid more than $68 PAC in current year, this is refunded as a current year overpayment.
Notes:	• *Member receives $60 of member rollover and $60 of State matching rollover. Rollover is applied at the start of May following the conclusion of calendar year 1.* • *$60 Member rollover is applied first and $40 State rollover dollars are applied next for CY 2.* • *Member does not need all the State rollover dollars, so the $20 State rollover returns to the State when the CY 2 account is reconciled.* • *Member has $20 more rollover than the member owed in PAC for CY 2. Member payments made in the CY 2 prior to the application of the rollover are refunded to the member at PRF reconciliation.* • *Member receives $32 of member rollover for CY 3. Member received preventive services, so this is matched by $32 of state rollover. Rollover is applied after the PRF reconciliation of CY 2.*		

Table 10 – Scenario 7: Member has terminated before rollover is processed

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$10 member + $10 state	N/A
Total Dollars Paid by Member	$10	$80	N/A
Total Member PAC Paid *(Rollover + Member $)*	$10	$100	N/A
Member PAC Owed	$10	$60 ($20 PAC x 3 months)	N/A
Member Dollars Remaining/ Member Rollover Earned for Following CY	$2,500	$800	N/A
Member Dollars Remaining	$10 x ($2,500/$2,500) = $10	N/A	N/A

State Matching Rollover Dollars	$10	N/A	N/A
Member Discount Percentage	N/A	N/A	N/A
Member overpayment refund amount	N/A	$20 member overpayment $15 ($20 overpayment due to rollover x .75) Total Refund: $35	N/A
Notes:	• *This member is eligible for $20 of rollover; however, member terminates three months into the calendar year 2 and does not return to HIP. This occurs when the account is being processed.* • *$10 Member rollover is applied first and $10 State rollover dollars are applied next for CY 2.* • *Member terminated 3 months into the CY 2. Member does not reenter the program. MCE takes rollover information into account when processing termination. Member is eligible for a refund of current dollars paid in and member rollover dollars remaining, less the amount allocated to claims. A 25% penalty applies for termination on the overpayment due to rollover which is why the member only receives $35 overpayment refund. The PRF reconciliation and member refunds of CY 2 payments and rollover are processed following the conclusion of CY 2.*		

Table 11 – Scenario 8: Member terminates for 4 months in the middle of year 2 and returns during the same calendar year

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$10 member + $10 state	$64 member rollover + $56 state match
Total Dollars Paid by Member	$10	$60	$0
Total Member PAC Paid *(Rollover + Member $)*	$10	$80	$120 (excess state match of $8 would return to the state)
Member PAC Owed	$10	$80	$120
Member Final Account Balance	$2,500	$2000	$2,500
Member Dollars Remaining/ Member Rollover Earned for Following CY	$10 x ($2,500/$2,500) = $10	$80 x ($2,000/$2,500) = $64	$120 x ($2,500/$2,500) = $120
State Matching Rollover Dollars	$10	$64	$120
Member Discount Percentage	N/A	N/A	N/A
Member overpayment refund amount	N/A	Any funds the member paid over $60 towards their PAC would be refunded as a current year overpayment	Member dollars paid in current year are refunded as member had enough rollover to cover entire year.
Notes:	• *This member is eligible for $20 of rollover. $10 Member rollover is applied first and $10 State rollover dollars are applied next for CY 2.* • *Member terminated 4 months into the 2nd calendar year but returned to HIP. Member terminated 4 months in CY 2 and returned to HIP. Member paid PAC for all 8 enrolled months active and is active in December so earns rollover. Member share is calculated based on enrolled months.* • *Member was enrolled in December of calendar year 2 and January of calendar year 3.* • *Member receives $128 rollover ($64 member and $64 state) for CY 3. Rollover is applied after the PRF reconciliation of CY 2.*		

Table 12 – Scenario 9: *HIP Plus* member becomes pregnant and moves to MAMA in year 2

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$1	N/A
Total Dollars Paid by Member	$12	$0	N/A
Total Member PAC Paid *(Rollover + Member $)*	$12	$1	N/A
Member PAC Owed	$12	$1 (for the month member was not MAMA)	N/A
Member Final Account Balance	$2,500	$800	N/A
Member Dollars Remaining/ Member Rollover Earned for Following CY	$12 x ($2,500/$2,500) = $12	$1 x ($800/$2,500) = $0.32	N/A
State Matching Rollover Dollars	$12	N/A	N/A
Member Discount Percentage	N/A	$800/$2,500= 32%	N/A

Member overpayment refund amount	N/A	$11 remaining rollover + any funds the member paid towards their PAC would be refunded as a current year overpayment.	N/A
Notes:	• *Member receives $24 rollover ($12 member and $12 state). Member rollover is applied first to CY 2. Member is in MAMA at time of application, so rollover dollars are applied to the account.* • *Claims stop being applied to POWER Account when member transitions. Member rollover dollars from CY 1 are refunded as an overpayment. Member receives both dollar and discount rollover as MAMA rollover eligibility is calculated as a HIP Basic member.* • *Member is eligible for $0.32 of current year rollover. The member also a discount of 32% when rollover is applied after moves out of MAMA.*		

Table 13 – Scenario 10: *HIP Basic* member becomes pregnant and moves to MAMA in year 2

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$0	$0
Total Dollars Paid by Member	$0	$0	$6
Total Member PAC Paid *(Rollover + Member $)*	$0	$0	$6
Member PAC Owed	$0	$0	$12 – 50% = $6
Member Final Account Balance	$2,500	$800	$2,500
Member Dollars Remaining/ Member Rollover Earned for Following CY	N/A	N/A	$6
State Matching Rollover Dollars	N/A	N/A	$6
Member Discount Percentage	50%	$800/$2,500= 32%	N/A
Member overpayment refund amount	N/A	Any funds the member paid towards their PAC would be refunded as a current year overpayment.	
Notes:	• *Member earns a 50% discount for CY 1 enrollment. This discount is applied in month 5 of CY 2, when the member is in MAMA status.* • *Member moved to MAMA 1 month into the new calendar year benefit period and was in MAMA for 11 months. Claims stop being applied to POWER Account when member transitions. Rollover discount percent is held on the account.* • *In month 1 of CY 3, member is no longer MAMA and 50% discount is released. Member moves to HIP Plus.* • *In month 5 of CY 3, member has a second discount applied of 32%. Since the existing 50% discount is greater than the 32% discount, the member continues their enrollment with a 50% discount for CY 3.* • *Member base PAC is $12 – member earns a 50% discount, so member pays $6 for the year and state funds the remainder for the calendar year.*		

Table 14 – Scenario 11: *HIP Plus* member with tobacco surcharge and receives preventive services in years 2 and 3

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$60	$48 member + $27 state
Total Dollars Paid by Member	$100	$90	$0
Total Member PAC Paid *(Rollover + Member $)*	$100	$150	$75
Member PAC Owed Tobacco Surcharge	$100	$100 $50	$50 $25
Total Member PAC Owed	$100	$150	$75
Member Final Account Balance	$1,500	$800	$2,500

Member Dollars Remaining/ Member Rollover Earned for Following CY	$100 x ($1,500/$2,500) = $60	$150 x ($800/$2,500) = $48 $32 is earned on PAC (2/3 of member dollars remaining) $16 is earned on Tobacco Surcharge (1/3 of member dollars remaining)	$75 x ($2,500/$2,500) = $75
State Matching Rollover Dollars	N/A	$32 (State does not match tobacco surcharge funds)	$50 (State does not match tobacco surcharge funds)
Member Discount Percentage	N/A	N/A	N/A
Member overpayment refund amount	N/A	Any funds the member paid over $90 towards their PAC would be refunded as a current year overpayment.	Member dollars paid in current year are refunded as member had enough rollover to cover entire year.
Notes:	• *Member receives $60 of rollover at end of calendar benefit period. Member did not get preventive services in CY 1, so this is not matched.* • *Member $60 of rollover is applied as a credit on the account to CY 2 after the PRF reconciliation of CY 1. If member had prepaid for entire year, member may be due a refund for an overpayment.* • *Member received preventative services for CY 2 and CY 3.* • *See Calendar year 3 applied rollover demonstrated in table below.* • *The unused $5 for State Rollover is refunded to the State during the reconciliation of CY 3.*		

Rollover Application for CY 3

		$48	*Member rollover*	*$32*	*State rollover*
$25	*Tobacco Surcharge*	*-$25*	*Member rollover applied*	*$0*	
$50	*PAC*	*-$23*	*Member rollover applied*	*-$27*	*State rollover applied*
$75	*Total PAC*	*$0*	*Remaining member rollover*	*$5*	*Remaining State rollover returned to the state.*

Table 15 – Scenario 12: *HIP Plus* member with tobacco surcharge and preventive services

	Calendar Year 1	Calendar Year 2	Calendar Year 3
Rollover Applied	N/A	$60 member + $60 state	$180
Total Dollars Paid by Member	$100	$240	$0
Total Member PAC Paid *(Rollover + Member $)*	$100	$360	$180
Member PAC Owed Tobacco Surcharge	$100	$240 $120	$120 $60
Total Member PAC Owed	$100	$360	$180
Member Final Account Balance	$1,500	$2,500	$2,500
Member Dollars Remaining/ Member Rollover Earned for Following CY	$100 x ($1,500/$2,500) = $60	$360 x ($2,500/$2,500) = $360 $240 is earned on PAC (2/3 of member dollars remaining) $240 is the max amount that can be earned.	$180 x ($2,500/$2,500) = $180
State Matching Rollover Dollars	$60	$240 (State does not match tobacco surcharge funds)	$120 (State does not match tobacco surcharge funds)
Member Discount Percentage	N/A	N/A	N/A

Member overpayment refund amount	N/A	Any funds the member paid over $240 towards their PAC would be refunded as a current year overpayment.	Member dollars paid in current year are refunded as member had enough rollover to cover entire year.
Notes:	• *Member receives $120 rollover ($60 member and $60 state) at end of CY 1 since they received preventative services.* • *Member $120 of total rollover is applied as a credit on the account after the PRF reconciliation of CY 1. If member had prepaid for entire year, member may be due a refund for an overpayment.* • *Member rollover amount on the submitted PRF cannot be greater than $240. Anything a member earns in member rollover above $240 must be refunded to the member as a current year overpayment.* • *Member receives $240 in member rollover and $240 in state rollover. ($480 in rollover). State rollover dollars may not be applied to the tobacco surcharge due.* • *See Calendar year 3 applied rollover demonstrated in table below.*		

Rollover Application for CY 3

		$240	*Member rollover*	*$240*	*State rollover*
$60	*Tobacco Surcharge*	*-$60*	*Member rollover applied*	*$0*	
$120	*PAC*	*-$120*	*Member rollover applied*	*-$0*	*State rollover applied*
$180	*Total PAC*	*$60*	*Remaining member rollover*	*$240*	*Remaining State rollover returned to the state.*

5.7.3 POWER Account Reconciliation Process

Healthy Indiana Plan (HIP) member Personal Wellness and Responsibility (POWER) Accounts are funded with $2,500 by a combination of member and state dollars. When the HIP member is first enrolled, the state makes an initial contribution to the managed care entity (MCE) of $1,300. During the eligibility period, the member makes monthly payments. Benefit periods are aligned with the calendar year, so POWER Account contributions are a monthly requirement.

POWER Accounts are reconciled via the POWER Account reconciliation file (PRF) process. This process determines the additional amount that needs to be paid from the state to the MCE or recouped from the MCE back to the state. Applicable member refunds, rollover, and debt are also determined during this process. In no case will the MCE ever be paid an amount in excess of $2,500 (combination of member and state funds) for a benefit period's POWER Account. POWER Account reconciliation processing differs based on if the member was terminated from HIP, transferred MCEs during or at the end of the benefit period, or is eligible for rollover.

When performing the POWER Account reconciliation function, the MCE must comply with the procedures set forth in this manual. The MCE must have the capability to transmit the required PRF definitions. The MCE must also meet the submission timeline provided by OMPP prior to the start of annual POWER Account reconciliations.

The following table contains the PRF terms and definitions.

Table 16 – PRF Definitions

PRF Term	Definition
Current Benefit Period	This is the benefit period that is currently underway. It may not be the benefit period the MCE is reconciling. Benefit periods are always a calendar year, January through December. This is also the benefit period where any rollover earned in the rollover benefit period is applied. *Example:* A *HIP Basic* member earned a discount during rollover benefit period. This discount is applied in the member's current benefit period.
Rollover Benefit Period	This is the benefit period that the member completed the actions that qualify him or her for rollover. Example: In their first year of HIP benefits, a *HIP Basic* member has $500 in claims and completes preventive services. This member qualifies for rollover. This first year of HIP benefits is the rollover benefit period when rollover is being a calculated in year 2.
Member Claims Responsibility Ratio	A member's claims responsibility ratio is based on the monthly Power Account Contribution (PAC) divided by the total POWER Account funds of $2,500. Example: Member has a $10 monthly PAC. If the member was eligible for all 12 months of the calendar year benefit period, the member's claims responsibility ratio is (120/2,500) =0.048. For the first $2,500 in claims, this member is responsible for: [claim dollar amount used by member multiplied by 0.048]
Member Claims Responsibility Percentage	Member claims responsibility ratio multiplied by 100. *Example:* The member has a claims responsibility ratio of 0.048. The member's claims responsibility percentage is (0.048 x 100) = 4.8%. The member is responsible for 4.8% of each claim for the first $2,500 in claims paid from their POWER Account.
Member Claims Responsibility	Total claims in benefit year paid from POWER Account multiplied by the member claims responsibility ratio. *Example:* During rollover reconciliation the POWER Account has $1,000 remaining. The member had $1,500 in claims for the rollover benefit period. The member claims responsibility ratio is 0.048. The member's claims responsibility is ($1,500 x 0.048) = $72.
Member PAC Paid	The amount of PAC the member paid in the benefit period.
Member PAC Owed	The amount of PAC the member owed in the benefit period, only for the months the member was enrolled.
Member Remaining Dollars	Any unused contribution dollars that did not go toward the member's claims responsibility. A member ending benefits in *HIP Basic* may have member dollars remaining if they were a prior *HIP Plus* member in any current or any proceeding benefit periods. If claims responsibility is less than what member paid in toward their PAC, then member dollars will remain (regardless of if member is *HIP Plus* or *HIP Basic* at the end of the benefit period).
Member Rollover Dollars	Member remaining dollars less any member debt or member rollover penalty.
State Matching Rollover Dollars	Available to members who were in *HIP Plus* at the end of the member's rollover benefit period who have member rollover dollars and received preventive care during the rollover benefit period. State matching rollover dollars are equal to member remaining dollars pre-debt and pre-application penalty when the member received preventive care. If the member received no preventive services, then state matching dollars will be zero. State matching dollars are calculated before any member debt is subtracted from rollover dollars. When calculating the state rollover amount on a tobacco surcharge member, a member will earn 2/3 of the member contributions remaining.

PRF Term	Definition
State Discount Percentage (For members who earned *Basic* rollover)	Calculated to determine the dollar amount discount regarding the PAC. For members that end their rollover period as a *HIP Basic* member and received preventive care. This is the value of the member's account 120 days after end of the rollover benefit period divided by $2,500. This is then multiplied by 100 to determine the remaining dollars percentage in the account out of the total $2,500. The maximum state discount percentage is 50%, and any amounts calculated higher than that equal 50%. *Example:* 120 days after the benefit period, a *HIP Basic* member has a POWER Account balance of $1,000. The *HIP Basic* member's state discount percentage is ($1,000/$2,500) x 100 = 40%. If member who is currently *HIP Basic* earns a state discount percentage, then they receive a *Potential Plus* at rollover and determine a reduced PAC with a 40% discount. State Discount Percentage is reported on the PRF as a whole number with no decimals.
State Discount Dollars (For members who earned *Basic* rollover)	For members that end their rollover period as a *HIP Basic* member and received preventive care. The state discount dollars is the member's PAC multiplied by the member's monthly PAC discount percentage, as calculated previously. Members that are in *HIP Plus* when they receive a state discount dollar rollover have the discount applied to their entire contiguous *HIP Plus* period. *Example:* The member's state discount percentage is 40% and their PAC is $10/month. The member's state discount dollars equal 40% x 10 =$4. The member's monthly PAC is discounted by $4 state discount dollars, leaving a monthly PAC of $6. The discount dollar amount is a "positive" amount. The member's PAC can be less than $1 when a discount is applied.
Contiguous *HIP Plus* Period	The period of *HIP Plus* coverage without a break in *HIP Basic* benefits. *Example:* If a member is *HIP Plus* in month one of their benefit period, *HIP Basic* in months two and three, and *HIP Plus i*n month four when rollover is applied, then the contiguous *HIP Plus* period starts in month four and ends at the end of the benefit period when rollover is applied, or when the member drops to *HIP Basic*, whichever is sooner.
Potential Plus	Fully eligible *HIP Basic* members with a PAC amount have the option to contribute to their POWER Account to gain *HIP Plus* coverage at redetermination or at rollover.
Member Rollover Penalty	A *HIP Basic* member that has member remaining dollars is subject to a member rollover penalty. This is a 25% penalty on the member's member remaining dollars. The penalty dollars are returned to the state.
Member Debt	*HIP Plus* members are responsible for paying a portion of the first $2,500 in claims. When *HIP Plus* members do not pay their full portion of claims, they incur debt. Member debt can be subtracted from member rollover dollars and used by the MCE to clear the member's debt. Any state matching rollover dollars are calculated prior the MCE subtracting debt from member rollover dollars. Debt is capped at: • Member claims responsibility less member PAC paid, or months of missed PAC whichever is less • ~~5%~~ Quarterly cost-share maximum
MCE Coverage Period Begin Date	This is the MCE coverage period for the benefit period that is being reconciled. The MCE coverage begin date is the date the member is assigned to the MCE with fully eligible HIP coverage. This date may come before the benefit period being reconciled. *Example*: If the member is fully eligible in HIP with the MCE the calendar year prior, the MCE will populate the previous calendar year effective date.
MCE Coverage End Date	The MCE coverage end date is the date the member's fully eligible HIP MCE assignment ends with the MCE. The member end date should be the last day of a month. The exception is if a member dies; then, the MCE end date is the date of death.

POWER Account data must be transmitted electronically within the following timelines.

5.7.4 PRF File Types and Submission

POWER Accounts are reconciled via the POWER Account reconciliation file (PRF) process. The PRF is used to reconcile POWER Accounts when a HIP member:

- Has coverage that ends between months 1 to 12 of enrollment without continuing HIP enrollment in another benefit year or transfers to another HIP MCE within the calendar benefit year (termination PRF- Initial Term [IT]/Final Term [FT])
- Becomes eligible for rollover following completion of a 12-month calendar year benefit period where they are enrolled in December and continue enrollment in HIP in January (rollover PRF- Initial Rollover [IR]/Final Rollover [FR] and Initial Rollover Transfer [IX]/Final Rollover Transfer [FX]).

MCEs are to use the PRF transaction type codes listed in Table 17 when submitting the PRF. More detail on each PRF transaction type is provided in sections 6, 7, 8, 11, and 12.

Table 17 – PRF Transaction Type Codes

Transaction Type Code	Description
IT	Initial Term
FT	Final Term
VT	Term Void*
IR	Initial Rollover
FR	Final Rollover
VR	Void Rollover*
IX	Initial Plan Transfer Rollover
FX	Plan Transfer Rollover
VX	Void Transfer Rollover*
RD	Void Record Delete
**Void transactions cannot be submitted through the PRF Interface File. See PRF Voids for the procedure to request a void.*	

5.8 POWER Account Reconciliation File

The POWER Account reconciliation file (PRF) contains the following information:

6. Member data
7. POWER Account fund allocation
8. Account usage
9. Member debt
10. Member preventive service utilization
11. Member claims
12. Member rollover amounts

The same PRF interface file layout is used for all transactions. There are 44 fields on the PRF interface file layout. The fields are validated by the fiscal agent before being loaded into *Core* Medicaid Management Information System (*Core*MMIS).

The file layout can be found on the state SharePoint site, or a copy can be obtained from the fiscal agent's Care Program Unit staff. PRF file-naming conventions are posted to the *MCE Secure Landing* page at in.gov/medicaid/partners.

The fiscal agent's Systems Unit accepts only one file from each MCE per day. When the MCE submits more than one PRF file per day, all files are rejected. A folder has been set up for each plan on File Exchange:

13. MDwise – Distribution/HIP Program/XXXL
14. Anthem – Distribution/HIP Program/XXXL
15. MHS – Distribution/HIP Program/XXXL
16. CareSource – Distribution/HIP Program/XXXL

5.8.1 POWER Account Reconciliation File Process

- Member contributions are a monthly contribution amount
  - This means that members will not have the potential to have debt created when a new POWER account begins each January and they have less than 12 months of *HIP Plus* enrollment
  - Members are responsible for premiums for the enrolled months only.
- No calculation of annual amount
- For the member enrolled 2-months with a $10 PAC, the member's pro rata share of claims is determined as $20/$2,500 or 0.008, meaning the member is responsible for 0.8% of every claim.
- If the entire account is spent, the member would owe $20.

5.8.2 POWER Account Reconciliation

- POWER accounts for members will only be reconciled one time per year in May, 121 calendar days after the end of the calendar year benefit period.
- Claims will be applied to the POWER Account using claims paid dates up to 120 days after the end of the calendar year benefit period, regardless of enrollment end date within the calendar year benefit period for term and rollover members. This ensures that claims for the full benefit period are captured should the member have a gap in eligibility.
- Members with less than 12 months of enrollment due to starting coverage in months other than January or having months without HIP coverage during the calendar year, may earn rollover.
  - Members must be enrolled in December and the following January to earn rollover.
  - State matching rollover dollars are only available on the member's owed contribution amount. For example, if the member had a $10 monthly contribution and paid $120 up front for 12 months of coverage and then was only enrolled for 8 months, if $0 claims were spent, the maximum state matching rollover would be $80.
  - MAMA members can earn rollover as *Basic* members, and have rollover applied for use when the member transitions out of MAMA status.
- Members that terminate early in the year can request a member refund for any prepaid portion of the account.

5.8.3 Historical POWER Account Reconciliation Information

The following are notes regarding how POWER Accounts were reconciled historically. These requirements are no longer in use. *This section is for historical reference only.*

5.8.3.1 Annualized Member Contributions

Before February 1, 2018, a member was responsible for paying an annualized contribution to their POWER Account regardless of length of enrollment. When the member's HIP enrollment and benefit period ended, the member's POWER Account was reconciled.

Effective benefit periods ending December 31, 2017, annual contributions move to required monthly contributions. Members that terminate without completing 12 months of enrollment will not have debt for months when they were not enrolled.

5.8.3.2 Initial State Contribution

The state makes an initial contribution of $1,300 to the POWER Account after the member is confirmed as fully eligible for the calendar year benefit period. The $1,300 payment comes across on the monthly POWER Account 820 capitation file. Before January 1, 2018, any MCE that had a member assigned to them received the initial $1300 contribution.

With the move to calendar year benefit periods effective in 2018, only one $1300 contribution will be paid per member, per calendar year. If the member has more than one MCE in the benefit period, only the first MCE receives the $1300 contribution. The subsequent MCE(s) will receive the $1300 contribution as part of the true-up when they reconcile the POWER Account.

5.8.3.3 Transfers POWER Account Reconciliations

Before January 1, 2018, if members transferred to another MCE within the Benefit Period a final plan transfer PRF would be submitted. The PRF types were initial final plan transfer (IP) and final plan transfer (FP). MCE 1 submitted a final plan transfer (FP) PRF to the fiscal agent within 121 calendar days of notification of the transfer to close out the member's POWER Account and transferred any remaining funds. Gainwell generated response file to return to MCE 1 and Gainwell sent PRF – FP to MCE 2. At the next capitation cycle, all claims are totaled via PRF, money was exchanged via the 820; true-up and recoups process occurred for MCE 1 while PRF payment was made to MCE 2 (remaining funds from POWER Account). If a void needed to occur, a void plan transfer (VP) PRF was assigned.

The plan transfer (IP/FP/VP) PRF types are no longer active in *Core*MMIS and no longer submitted by MCEs.

5.8.3.4 Prior Year Unused Rollover

Before January 1, 2018, if a member had remaining rollover from a prior year the rollover would continue to carry over until it was depleted. This required MCEs to indicate on the POWER Account reconciliation how much prior year unused rollover remained and the fiscal agent would recoup and repay the unused amount on the 820 capitation using capitation reason codes RY (prior year unused rollover – member recoup) and PY (prior year unused rollover – member payout). This caused members to roll over unused rollover year after year.

Currently, the maximum amount of member rollover allowed on the rollover (IR/FR) or rollover transfer (IX/FX) PRF submission is $240 and the rest will be refunded to the member as a current year overpayment. The RY and PY capitation reason codes, field 37 and field 38 on the PRF Interface file are no longer used.

5.9 PRF Validation

5.9.1 Validation Queries

To validate MCE's PRF reconciliation process and calculation of refund amounts for members who are terminated, and rollover amounts earned by members, the state created validation queries for term and rollover PRFs. Effective with benefit periods greater than and equal to January 1, 2019, MCEs are responsible for validating their transactions through these queries prior to submitting the PRF to the fiscal agent. The validation queries can be found on the state HIP POWER Account SharePoint site.

5.9.2 CoreMMIS Edits

All POWER Account (PRF) reconciliations go through edits when submitted to *Core*MMIS. If the PRF hits an edit, the MCE will receive a response on the outbound file. MCEs must review the response, make any necessary corrections, and resubmit the PRF. All resubmissions must be resubmitted within the submission timeline provided by OMPP.

Edits will tell MCEs that a PRF should be a rollover and not a term or vice versa. It will also tell the MCE what effective dates should be used for the member. A full list of PRF Edits can be found in the PRF Interface File specifications. Instructions for what to do for each type of response can be found on the state HIP POWER Account SharePoint site.

5.9.3 PRF Exceptions

OMPP conducts back-end reporting with FSSA Social Services Data Warehouse (SSDW). Using eligibility data and PRF reconciliation data, PRF Exceptions may be identified on the SSDW Weekly Submission Reporting. Exceptions are created when the PRF type submitted does not match what should have been submitted. For example, if an MCE submitted a PRF as a term but the member has had eligibility updated to reflect, they are a rollover, the PRF will show as an exception.

OMPP will send these Exceptions to the MCEs to review. MCEs will work with OMPP to determine if corrections and a resubmission need to occur. All Exceptions must be cleaned up within the timeline provided by OMPP.

5.9.3.1 HIP Plus Rollover

Healthy Indiana Plan *(HIP) Basic* members and *HIP State Plan Basic* members not contributing to their Personal Wellness and Responsibility (POWER) Accounts may have the ability to roll over funds. These individuals will still maintain the incentive to manage the account judiciously and receive recommended preventative care services. The discount available to *HIP Basic* members is 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 plan year, then they may reduce their required *HIP Plus* contribution by 40% in the following year by having the discount apply as a credit, provided they have received their recommended preventive services. However, this discount is limited to a maximum of 50% of the member's owed contribution.

A member's rollover benefit period is the period in which rollover is earned. For ongoing HIP members, rollover dollars are applied to the member's current benefit period. Members that are in *HIP Basic* or *HIP State Plan Basic* at the end of the rollover benefit period qualify for a state discount rollover if:

17. There are still funds in the $2,500 POWER Account.
18. The member has completed preventive services:

- *HIP Basic* members qualify for a state discount percentage, which is translated into state discount dollars, or a dollar amount off of their POWER Account contribution (PAC) for *HIP Plus* or *HIP Potential Plus* segment (depending on their current status).
- The state discount percentage is based on the percentage of the POWER Account that is remaining based on member's claims usage.
- The state discount percentage should not exceed 50%. This percentage is applied against the member's current PAC to calculate the state discount dollars. *HIP Basic* members qualify to roll over unused member contributions or prior year rollover that they previously paid in as a *HIP Plus* member. These can be rolled over even if the member has not completed preventive services. Because of nonpayment and dropping to *HIP Basic,* any member contributions are subject to a 25%-member rollover penalty before being applied to the member's current POWER Account.
- Rollover discounts apply to the current benefit period and expire at the end of benefit period in which they are applied for members that earned *HIP Basic* rollover.
- Members that are *HIP Basic* members when a percent discount is applied only receive the percent discount on months of *HIP Plus* coverage following the rollover calculation.
- Members that are *HIP Plus* members when a *HIP Basic* member discount is being applied have the discount applied to their entire contiguous period as a *HIP Plus* member where they have not had a break to *HIP Basic* coverage, not just prospectively. Members can receive discounts on PAC already paid in current year when rollover is applied. For a member that changed to *HIP Plus* in the first of month of the enrollment period the discount could go back as far as the first month of the current benefit period. Discounts do not apply to the previous benefit period.
- *HIP Basic* members that have member rollover dollars or rollover from a prior *HIP Plus* enrollment have these contributions carried forward and applied to their *Potential Plus* required contribution amount. The contributions rolled over have a 25% penalty amount applied to them. The 25% penalty is returned to the state. *HIP Basic* members can qualify for this rollover even if they did not have preventive care.

Members that are in *HIP Plus Copay* at the end of their benefit period must meet the same conditions as *HIP Basic* members to qualify for rollover.

Members that are in *HIP Basic* at the end of the rollover benefit period may have member dollars and percentage discount. In that case, the discount is applied first and then the credits are applied to the remaining balance. For all HIP members who are continuing in the program, MCEs are responsible for submitting a rollover POWER Account reconciliation file (PRF) to Gainwell at the end of the member's rollover benefit period regardless of if the member was eligible for rollover or not. Gainwell submits rollover information to Indiana Eligibility Determination Services System (IEDSS)Indiana Eligibility Determination Services System (IEDSS) on all members.

For members that are in *HIP Basic* or *HIP State Plan Basic* in their current benefit period when rollover is being applied, including state discount dollar rollover, member rollover dollars, and/or state matching dollars, this generates a *Potential Plus* segment. The *HIP Potential Plus* indicator and state discount dollars come on the 834, whereas member rollover dollars and state matching rollover dollars are only on the PRF not transmitted via the 834 and only earned as *HIP Plus* member.

19. If the member qualifies for a *Potential Plus* segment, then IEDSS sends a *Potential Plus* to Gainwell. Gainwell updates the *Potential Plus* loop with any applicable state discount dollar information to the member's managed care entity (MCE).
    - Current *HIP Basic* members that qualify for state discount dollars have these dollars applied to reduce their *Potential Plus* PAC going forward. Members that qualify for member rollover dollars and/or state matching dollars have these dollars applied as a credit on their account.

- If there are enough rollover dollars to cover at least one month of PAC, then the MCE may apply this credit to the PAC owed in the current month and send a pay file for the member to convert them to *HIP Plus*. The pay file should be received by the last Friday of the month following the POWER Account reconciliation. If there are not enough rollover dollars to cover at least one month's PAC, then the MCE may apply the dollars to the account and invoice the member for the balance.
- State discount dollars are applied to the original PAC (for example, before the application of any member or state rollover dollars).
- Members that have state discount dollars and experience PAC changes have the state discount percentage applied to their new PAC and receive an updated state discount dollar amount.

20. Members in *HIP Plus Copay* at the end of their rollover benefit period earn rollover like *HIP Basic* members.
    - Members in *HIP Plus Copay* when rollover is being applied will direct open into *HIP Plus* status as it occurs with redetermination.
    - Any state discount percentage is applied to the member's PAC on a go forward basis. It does not reduce the *HIP Plus Copay* PAC retroactively.
    - Any member rollover dollars or state rollover dollars are applied to the account as a credit.

If there are enough dollars to cover at least one month of PAC, then the MCE may send a pay file and the member will convert from *Potential Plus Copay* to *HIP State Plan Plus.*

5.9.3.2 HIP Basic Rollover

Healthy Indiana Plan *(HIP) Basic* members and *HIP State Plan Basic* members not contributing to their Personal Wellness and Responsibility (POWER) Accounts may have the ability to roll over funds. These individuals will still maintain the incentive to manage the account judiciously and receive recommended preventative care services. The discount available to *HIP Basic* members is 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 plan year, then they may reduce their required *HIP Plus* contribution by 40% in the following year by having the discount apply as a credit, provided they have received their recommended preventive services. However, this discount is limited to a maximum of 50% of the member's owed contribution.

A member's rollover benefit period is the period in which rollover is earned. For ongoing HIP members, rollover dollars are applied to the member's current benefit period. Members that are in *HIP Basic* or *HIP State Plan Basic* at the end of the rollover benefit period qualify for a state discount rollover if:

1. There are still funds in the $2,500 POWER Account.
2. The member has completed preventive services:
    - *HIP Basic* members qualify for a state discount percentage, which is translated into state discount dollars, or a dollar amount off of their POWER Account contribution (PAC) for *HIP Plus* or *HIP Potential Plus* segment (depending on their current status).
    - The state discount percentage is based on the percentage of the POWER Account that is remaining based on member's claims usage.
    - The state discount percentage should not exceed 50%. This percentage is applied against the member's current PAC to calculate the state discount dollars. *HIP Basic* members qualify to roll over unused member contributions or prior year rollover that they previously paid in as a *HIP Plus* member. These can be rolled over even if the member has not completed preventive services.

Because of nonpayment and dropping to *HIP Basic,* any member contributions are subject to a 25%-member rollover penalty before being applied to the member's current POWER Account.

- Rollover discounts apply to the current benefit period and expire at the end of benefit period in which they are applied for members that earned *HIP Basic* rollover.
- Members that are *HIP Basic* members when a percent discount is applied only receive the percent discount on months of *HIP Plus* coverage following the rollover calculation.
- Members that are *HIP Plus* members when a *HIP Basic* member discount is being applied have the discount applied to their entire contiguous period as a *HIP Plus* member where they have not had a break to *HIP Basic* coverage, not just prospectively. Members can receive discounts on PAC already paid in current year when rollover is applied. For a member that changed to *HIP Plus* in the first of month of the enrollment period the discount could go back as far as the first month of the current benefit period. Discounts do not apply to the previous benefit period.
- *HIP Basic* members that have member rollover dollars or rollover from a prior *HIP Plus* enrollment have these contributions carried forward and applied to their *Potential Plus* required contribution amount. The contributions rolled over have a 25% penalty amount applied to them. The 25% penalty is returned to the state. *HIP Basic* members can qualify for this rollover even if they did not have preventive care.

Members that are in *HIP Plus Copay* at the end of their benefit period must meet the same conditions as *HIP Basic* members to qualify for rollover.

Members that are in *HIP Basic* at the end of the rollover benefit period may have member dollars and percentage discount. In that case, the discount is applied first and then the credits are applied to the remaining balance. For all HIP members who are continuing in the program, MCEs are responsible for submitting a rollover POWER Account reconciliation file (PRF) to Gainwell at the end of the member's rollover benefit period regardless of if the member was eligible for rollover or not. Gainwell submits rollover information to Indiana Eligibility Determination Services System (IEDSS)Indiana Eligibility Determination Services System (IEDSS) on all members.

For members that are in *HIP Basic* or *HIP State Plan Basic* in their current benefit period when rollover is being applied, including state discount dollar rollover, member rollover dollars, and/or state matching dollars, this generates a *Potential Plus* segment. The *HIP Potential Plus* indicator and state discount dollars come on the 834, whereas member rollover dollars and state matching rollover dollars are only on the PRF not transmitted via the 834 and only earned as *HIP Plus* member.

3. If the member qualifies for a *Potential Plus* segment, then IEDSS sends a *Potential Plus* to Gainwell. Gainwell updates the *Potential Plus* loop with any applicable state discount dollar information to the member's managed care entity (MCE).
    - Current *HIP Basic* members that qualify for state discount dollars have these dollars applied to reduce their *Potential Plus* PAC going forward. Members that qualify for member rollover dollars and/or state matching dollars have these dollars applied as a credit on their account.
    - If there are enough rollover dollars to cover at least one month of PAC, then the MCE may apply this credit to the PAC owed in the current month and send a pay file for the member to convert them to *HIP Plus*. The pay file should be received by the last Friday of the month following the POWER Account reconciliation. If there are not enough rollover dollars to cover at least one month's PAC, then the MCE may apply the dollars to the account and invoice the member for the balance.
    - State discount dollars are applied to the original PAC (for example, before the application of any member or state rollover dollars).

- Members that have state discount dollars and experience PAC changes have the state discount percentage applied to their new PAC and receive an updated state discount dollar amount.

4. Members in *HIP Plus Copay* at the end of their rollover benefit period earn rollover like *HIP Basic* members.

   - Members in *HIP Plus Copay* when rollover is being applied will direct open into *HIP Plus* status as it occurs with redetermination.

   - Any state discount percentage is applied to the member's PAC on a go forward basis. It does not reduce the *HIP Plus Copay* PAC retroactively.

   - Any member rollover dollars or state rollover dollars are applied to the account as a credit.

If there are enough dollars to cover at least one month of PAC, then the MCE may send a pay file and the member will convert from *Potential Plus Copay* to *HIP State Plan Plus.*

5.9.4 Recommended Preventive Care Services

The member pro rata share of each claim is calculated as $135/$2,500 = 0.054. The tobacco surcharge is considered when calculating member pro rata share. Healthy Indiana Plan *(HIP) Plus* members and *HIP State Plan Plus* members who consistently contribute to their Personal Wellness and Responsibility (POWER) Accounts during the plan year will be eligible to roll over their unused pro rata share of the POWER Account balance. Claims payment allocation from a POWER Account should always be based on the current year POWER Account contribution.

If a *HIP Plus* or *HIP State Plan Plus* member receives any recommended preventive care services during the plan year, then the member is eligible to have their unused share, or "rollover amount," doubled by the state as an added incentive. Because final rollover occurs 121 days after the start of the subsequent benefit period, the rollover amount would be applied on a prospective basis for the remaining benefit period to reduce the member's future monthly payment. The member's rollover amount is used first to offset a member's required contribution and could eliminate required contributions in the applicable plan year. After the member rollover amount is exhausted, the additional state rollover incentive amount is used to offset the remaining portion of a member's required contribution and up to the total amount of the member's contribution for the year. Unused state matching dollars are lost to the member and returned to the state. Unused excess member rollover for that year remains the member's money and is refunded.

- The managed care entity (MCE) must refund any member overpayments within 150 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 their 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.

5.10 PRF Terminations (IT/FT)

Members who are not continuing in Healthy Indiana Plan (HIP) in January following the benefit period have their Personal Wellness and Responsibility (POWER) Account reconciled through the POWER Account reconciliation file (PRF) termination process. A termination (also known as a *term*) is defined as a member completely terminating out of the HIP program.

If a member becomes ineligible for HIP, then the managed care entity (MCE) must close the member's POWER Account and refund the state's and member's shares of the remaining POWER Account balance,

if any, in addition to determining if the member owes any debt at the conclusion of the calendar year benefit period.

Effective for benefit periods greater than or equal to January 1, 2018, if a member terms from an MCE and moves to another MCE during the calendar year benefit period, the PRF termination process is also utilized.

5.10.1 POWER Account Reconciliation File Timing – Term

The MCE receives initial term information on the 834 with record type 001 from Gainwell on the following day after receipt of the record on the state's eligibility input file indicating the upcoming termination date. The MCE receives this termination notification record with record type 024 a day after the termination takes effect. Terminations are effective the first day of month following the termination.

On the 30th day after the HIP calendar year benefit period ends, Gainwell receives an initial term (IT) PRF from the MCE. On day 31, Gainwell generates a response file and sends the file to the MCE. The response file informs the MCE whether or not the file was valid. There is no 820 impact on the initial PRF. Initial PRFs also cannot be voided or deleted from *Core*MMIS.

At 121 calendar 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. This file identifies the amount of any MCE payments owed, state refunds owed, and member refunds owed. This inbound PRF triggers Gainwell to send a response file to the MCE. After the receipt of the final PRF is processed via the 820 transaction file, the financial cycle is run, and MCE recoups and MCE true-ups are processed. MCEs refund the member within 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. Member refunds may have a 25% penalty applied if the member was terminated for reason of nonpayment as detailed in *Member Termination Refund*.

All term PRF transactions must be successfully processed following the timeline provided by OMPP.

5.10.2 Member Termination 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 150 days after the end of the calendar year benefit period.

The MCE must also refund the member's unused member contributions less the *pro rata* share, if any. The refund must be provided within 150 calendar days of the calendar year benefit period end. This allows time for the processing of the PRF reconciliation. If the MCE sends a POWER Account refund check to a member and the check is returned to the MCE because the member cannot be located, then the MCE must handle the member's unclaimed refund pursuant to Indiana Statute (*IC 32-34-1*, et seq.).

A deceased member's estate has a right to the member's pro rata share of their POWER Account funds.

When a member who does not meet any of the disenrollment exceptions is terminated from HIP for nonpayment, the member forfeits to the state 25% of their *pro rata* share of remaining member PACs. The MCE would use NP (nonpayment) as the reason code to apply the penalty. This means that for member termination from HIP because of nonpayment, the MCE is required to refund 75% of the member's *pro rata* share of the POWER Account.

Member Termination Refund is calculated as:

1. Determine the member pro rata share of the POWER Account.
2. Multiply the member pro rata share of the POWER Account by the amount of claims incurred.

3. Determine the amount of member PACs paid in the benefit period.
4. Subtract the amount in step 2 from the amount in step 3.
5. If the amount in step 4 is positive, then the member is owed a refund, if the amount in step 4 is negative, the member has debt.
6. If the member has a refund, then multiply the refund amount determined under step 4 by 0.75 or 75%, as applicable (nonpayment).

Example:

Benefit Period: PAC 12 months is $20 per month

Month	1	2	3	4	5	6	7	8	9	10	11	12
PAC	20	20	20	20	20	20	20	20	20	20	20	20

- Member Portion (amount of the POWER account the member owes for the benefit period): $20 x 12= $240
- State Portion (the amount the state owes for the benefit period): $2,500-$240 = $2,260.
- Member pro-rata share is calculated as: $240/$2,500 = .096
- In this example the member is responsible for 9.6% of each claim up to the $2,500 limit (with the $240 member share).

> ***Note:*** *A claim of $250 is applies to the POWER account for this member. $250 is deducted from the POWER account. The member portion of this claim is $250*.096 = $24. $24 is allocated to the member portion of the account and ($250-$24) =$226 is allocated to the state portion of the account.*

Scenario Amounts	Pro Rata Share and Refund Steps
9.6%	1. Determine the member pro rata share of the POWER Account.
$192	2. Multiply the member pro rata share of the POWER Account by the amount of claims incurred. ($2000 claims x .096 = $192)
$240	3. Determine the amount of member PACs paid in the benefit period. ($20 PAC x 12 months)
$48	4. Subtract the amount in step 2 from the amount in step 3. ($240 - $192)
Refund = $48	5. If the amount in step 4 is positive, then the member is owed a refund, if the amount in step 4 is negative, the member has debt.
$0 if doesn't term for nonpayment $36 if term for nonpayment	6. If the member has a refund and terminates for non-payment, then multiply the refund amount determined under step 4 by 0.75 or 75%, as applicable (nonpayment).

Member refunds must be reported even if the amount is zero. After the PRF is filed 121 calendar days following the end of the calendar year benefit period, the MCE may not make further adjustments. The MCE is responsible for any claims received after the POWER Account has been reconciled and the member refund has been issued. The MCE shall not pursue the member's portion of an appealed claim after a member refund has been made.

The penalty should always be applied to members who are terminated for failure to pay or are *HIP Basic* members in December or in the last month of enrollment in the calendar year being reconciled who were *HIP Plus* at some point during the year.

5.11 POWER Account Debt Collection Process

At 121 calendar days following the end of a member's calendar year benefit period, the managed care entity (MCE) must notify the state fiscal agent of the amount of the member and state refunds and other data. This information must be provided on the Personal Wellness and Responsibility (POWER) Account

reconciliation file (PRF). The MCE may collect any member debt from the member portion of rollover funds determined in accordance with the rollover calculations specific to *HIP Plus* and *HIP Basic*.

Healthy Indiana Plan (HIP) members are responsible for a share of the deductible. A member may incur debt to the MCEs through using the pre-funded POWER Account before fully funding the member's pro rata share of the deductible. POWER Account contributions (PACs) are member contributions toward a deductible and not a monthly premium. Member debt is based on the percent of the deductible the member was responsible for and how much of the POWER Account was spent to pay the deductible.

Relative to rollover, member debt may be collected from member rollover. Any current year past due balances are reconciled before calculating rollover; prior year's debt would be subtracted from member rollover dollars after state matching dollars are calculated. Under no circumstances shall state rollover funds be used to pay member debt. state matching funds must be calculated before determining member owed debt. The owed amount can then be deducted from the amount of member dollars being rolled over into the benefit period.

For purposes of clarification, only the pre-funded amount of the deductible that was used by the member, but not paid before termination or transfer to *HIP Basic,* will become a debt to the MCE. Any member debt collected must be applied to the 5% quarterly cost-share maximum.

The MCE may collect any debt owed by the member to the MCE. The MCE must send a letter to the member explaining that they owe debt and the amount owed. If the MCE pursues the member debt, the MCE must do so in accordance with standard company practice for collection of debt in the individual market segment. However, the MCE may **NOT** use any of the following debt collection measures in the collection of member debt:

1. Sell the member's debt
2. Report the debt to credit reporting agencies
3. Place a lien on the member's home
4. Refer the case to debt collector
5. File a lawsuit
6. Seek a court order to seize a portion of the member's earnings

The MCE may also collect debt out of the refunds owed to its member, as well as from the member's portion of rollover each year. All debt collected must be reported in quarterly reporting according to the *MCE Reporting Manual* and may be subject to an audit. Any debt collected from the member must apply toward the member's quarterly 5% cost-sharing maximum. However, debt collected out of member refunds or rollover funds do not apply toward the member's quarterly 5% cost-sharing maximum.

5.11.1 Debt Calculation

The amount of debt a member may accrue is capped at an amount equal to:

1. The member's pro rata share of claims incurred, less contributions made by the member
2. $240 per year or $360 with a tobacco surcharge

Debt is the lesser of these two amounts listed above

Members can only owe debt for months where they were enrolled but did not pay.

Example 1: Member A has a monthly PAC responsibility of $10. Member A is enrolled for five months. Member A pays their PAC for the first three months of coverage and then stops paying. The member is subject to termination of coverage effective the first of the month following the end of their 60-day grace period. The member has incurred $2,000 in claims during their *HIP Plus* enrollment.

The following table shows the calculation of debt for Member A:

Table 18 – Debt Calculation

Member pro rata share	$50/2500 = 0.02
Member pro rata share of claims	$2,000 x 0.02 = $40.00
Member contributions paid	3 x $10 = $30
Member remaining share of claims incurred	$40 - $30 = $10.00
Members months of missed PAC	2 x $10 = $20.00
Quarterly cost share	3 x $10 = $30.00
Maximum debt check	
Member Claims responsibility (pro rata share from above) - Member contributions paid	$10.00
Member missed PAC (above)	$20.00
Member debt is the lesser of the two amounts and cannot exceed the Quarterly cost share.	
Member debt	$10.00

5.11.2 Collection of Debt

Any debt paid by the member during the quarter needs to be included in the member 5% cost-sharing limit. If the MCE is aware of or has proof provided by the member of debt paid equal to 5% of their quarterly income, then all other cost-sharing should stop for the remainder of the quarter, with the exception of the $1 minimum *HIP Plus* contribution.

5.11.3 Past Due Payments and Debt

After a member has been subject to a negative consequence for nonpayment, including dropping to *HIP Basic* or *HIP Plus Copay* or termination from HIP, any past due amounts owed by the member become member debt after the benefit period is reconciled and only if there is pro rata share of claims due. Repayment of member debt cannot be a contingency of re-entry into HIP or re-entry in *HIP Plus* if the member receives a *Potential Plus* segment.

Example 1: Member starts coverage in January as a *HIP Plus* member. Member drops to *HIP Basic* in April. In May, member gets a *HIP Potential Plus* segment. The MCE may only require the member to pay the one month of PAC on the *Potential Plus* segment for the member to re-enter *HIP Plus*. Unpaid balances from the prior plus segment can be collected subject to the debt restrictions.
Example 2: Member terminates from coverage because of nonpayment in May. The member ~~is eligible for a lockout exemption and~~ reapplies and returns for coverage with the same MCE in July. The member pays their PAC amount for July. This payment cannot be applied to the member's prior nonpayment but must count as a payment for the current month. The prior nonpayments may be collected from the member subject to debt limitations.

5.12 Calculation of the Member Portion of the Account for 12-Month Member Enrollment

To determine the member portion of the Personal Wellness and Responsibility (POWER) Account:

- Sum the amount the member owed for every month in which a POWER account contribution was applicable, and the member was enrolled.

Example: 12-Month Continuous Eligibility
POWER Account contribution (PAC) for Months 1 to 6 is $10, PAC for months 7 to 12 is $5.

Month	1	2	3	4	5	6	7	8	9	10	11	12
PAC	$10	$10	$10	$10	$10	$10	$5	$5	$5	$5	$5	$5

Member Portion: ($10 x 6) + ($5 x 6) = $90
- This represents the amount of the POWER Account the member owes for the benefit period, or the member portion, assuming the entire POWER Account was expended.

State Portion: $2,500 - $90 = $2,410
- This represents the amount the state owes for the benefit period, or the state portion, assuming the entire POWER Account was expended.

5.13 Calculation of the Member Portion of the Account for Terminations and Transfers for Enrollment Periods Less than 12 Months

Member POWER account contributions are a monthly amount. To calculate the member portion of the account for members who have eligibility periods that are shorter than 12 months, the PAC owed for the enrolled months should be summed.

Example: Short Eligibility Period 1
PAC for months 1-6 is $10, PAC for month 7 is $5. Member is terminated effective the end of month 7.

Month	1	2	3	4	5	6	7	8	9	10	11		12
PAC	$10	$10	$10	$10	$10	$10	$5	TERM	TERM	TERM	TERM		TERM

The member only owes PACs for the months they are enrolled. To calculate the member portion of the account for the determination of member pro rata share, only the POWER Account total amount owed for the enrolled months is used.
- Sum the member's PAC amount for every enrollment month. This is the PAC amount owed.
  - ($10 x 6) + $5 = $65

There is no PAC amount applied for months 8-12 since the member had termed. If the member was only enrolled for 7 months and the entire POWER Account was expended, the member would still only owe $65.

Example: Short Eligibility Period 2
POWER accounts are effective on a calendar year basis. Members may terminate and re-enter the program during the calendar year. All enrolled months are considered when determining the member's pro rata share.

PAC for months 1-3 is $10. Member terminates for months 4-7. PAC for months 8-12 is $5.

Month	1	2	3	4	5	6	7	8	9	10	11	12
PAC	$10	$10	$10	TERM	TERM	TERM	TERM	$5	$5	$5	$5	$5

The member only owes PACs for the months they are active/enrolled. To calculate the member portion of the account for the determination of member pro rata share, the POWER Account amount owed for only the enrolled months is used.
- Sum the member's PAC amount for every enrollment month. This is the PAC amount owed.
  ($10 x 3) + ($5 x 5) = $55

There is no PAC amount applied for months 4-7 since the member had terminated. If the member was only enrolled for 8 months and the entire POWER Account was expended, the member would still only owe $55.

5.14 Calculation of Member Pro Rata Share

Member pro rata share is equal to the proportion of the POWER Account the member is responsible for contributing. When members do not fully expend their POWER Account, claims are applied on a pro rata share basis. The percent of each claim for which the member is responsible for up to $2,500 is calculated as Sum of Monthly Member Portion/$2,500.

Example 1: From the example for the 12-month continuous eligibility period previously described; the member pro rata share is calculated as:

Month	1	2	3	4	5	6	7	8	9	10	11	12
PAC	$10	$10	$10	$10	$10	$10	$5	$5	$5	$5	$5	$5

Member Portion: ($10 x 6) + ($5 x 6) = $90

Member Pro Rata Share: Sum of monthly PAC/$2,500. $90/$2,500 = 0.036. In this case, the member is responsible for 3.6% of each claim up to the $2,500 limit (with the $90 member share).

A claim of $250 is applied to the POWER Account for this member. $250 is deducted from the POWER Account. The member portion of this claim is $250 x 0.036 = $9.

$9 is allocated to the member portion of the account and ($250 - $9) = $241 is allocated to the state portion of the account.

Example 2: From the short eligibility period example 1 above, the member pro rata share is calculated as:

Month	1	2	3	4	5	6	7	8	9	10	11	12
PAC	$10	$10	$10	$10	$10	$10	$5	TERM	TERM	TERM	TERM	TERM

Member Portion: ($10 x 6) + $5 = $65

Member Pro Rata Share: Sum of monthly PAC/$2,500. $65/$2,500 = 0.026. In this case the member is responsible for 2.6% of each claim up to the $2,500 limit (with the $65 member share).

A claim of $250 is applied to the POWER Account for this member. $250 is deducted from the POWER Account. The member portion of this claim is: $250 x 0.0272 = $6.50

$6.50 is allocated to the member portion of the account and ($250 - $6.50) = $243.50 is allocated to the state portion of the account.

5.15 Calculation of the Member Portion of the POWER Account for 12-Month Member Enrollment with Transition to HIP Maternity (MAMA)

To determine the member portion of the POWER Account:

- Sum the amount the member owed for every month in which a POWER Account contribution was applicable (member was eligible)

Example: Transition to MAMA
PAC for months 1, 2, and 12 is $10. There is no PAC for months 3 to 11 since member transitioned to MAMA. Claims are not deducted from the POWER Account for the MAMA months of enrollment.

Month	1	2	3	4	5	6	7	8	9	10	11	12
PAC	$10	$10	MAMA	MAMA	MAMA	MAMA	MAMA	MAMA	MAMA	MAMA	MAMA	$10

Member Portion: $10 x 3 = $30
- This represents the amount of the POWER Account the member owes for the benefit period, or the member portion, assuming the entire POWER Account was expended.

State Portion: $2,500 - $30 = $2,470.
- This represents the amount the state owes for the benefit period, or the state portion, assuming the entire POWER Account was expended.
- Member pro rata share is $30/$2,500 = 0.012. For claims during months 1, 2, and 12, the member is responsible for 1.2% of total claims cost.

Notes:
- Claims may still be applied for dates of services prior to the report of pregnancy and for months the member was not in MAMA.
- Members may have a rollover applied to them while in the MAMA category. These dollars may be held on the member's account for application to premium amount for when the member exits MAMA.

5.16 Calculation of the Member Portion of the POWER Account for 12-Month Member Enrollment with Tobacco Indicator

Effective January 1, 2019, members that use tobacco have a tobacco indicator assigned and will be assessed a tobacco surcharge. The tobacco surcharge must be taken into account when reconciling the POWER Accounts beginning with 2019 benefit periods. The first time MCEs will reconcile a POWER Account with a tobacco surcharge is in year 2020.

To determine the member portion of the POWER Account:
- Step 1: Sum the amount the member owed for every month in which a POWER Account contribution was applicable (member was eligible)
- Step 2: Sum the amount of the tobacco surcharge the member owed for every month in which a POWER Account contribution was applicable (member was eligible)

Example: Tobacco Surcharge
PAC for months 1 to 6 is $10. PAC for months 7 to 12 is $5. Tobacco surcharge is $5 for the first six months and $2.50 for the second six months.

Month	1	2	3	4	5	6	7	8	9	10	11	12
PAC	$10	$10	$10	$10	$10	$10	$5	$5	$5	$5	$5	$5
Tobacco Surcharge	$5	$5	$5	$5	$5	$5	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50

Member Portion: ($10 x 6) + ($5 x 6) + ($5 x 6) + ($2.50 x 6) = $135
- This represents the amount of the POWER Account the member owes for the benefit period, or the member portion, assuming the entire POWER Account was expended.

State Portion: $2,500 - $135 = $2,365.

- This represents the amount the state owes for the benefit period, or the state portion, assuming the entire POWER Account was expended.

5.17 POWER Account Reconciliation File Transfers Mid-Benefit Year

There may be members who transfer managed care entities (MCEs) during a benefit year for just cause. When a member transfers to another MCE during their benefit period, the MCE must complete the POWER Account reconciliation file (PRF). As stated above, if a member terms from an MCE and moves to another MCE during the calendar year benefit period, the PRF termination process is utilized. MCEs must submit a termination (IT/FT) transaction.

To transfer a member from one MCE to another, the fiscal agent generates 834-02 term record and sends it to the MCE that the member is transferring from (MCE 1). There will be a JH reason code populated on the 834 to MCE 1 to show a transfer. The new MCE (MCE 2) receives the 834 021 add record indicating that member is transferring to them for the current benefit period.

On the 30th day after the HIP calendar year benefit period ends, Gainwell receives an initial term (IT) PRF from the MCE. On day 31, Gainwell generates a response file and sends the file to the MCE. The response file informs the MCE whether or not the file was valid. There is no 820 impact on the initial PRF. Initial PRFs also cannot be voided or deleted from *Core*MMIS.

At 121 calendar 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. This file identifies the amount of any MCE payments owed, state refunds owed, and member refunds owed. This inbound PRF triggers Gainwell to send a response file to the MCE. After the receipt of the final PRF is processed via the 820 transaction file, the financial cycle is run, and MCE recoups and MCE true-ups are processed. MCEs refund the member within 120 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. Member refunds may have a 25% penalty applied if the member was terminated for a penalty reason of nonpayment as detailed in *Member Termination Refund*.

All mid-year transfer term PRF transactions must be successfully processed following the timeline provided by OMPP.

5.18 POWER Account Reconciliation File Rollover Transfers (IX/FX)

If a member transfers to a new health plan at the end of the calendar year benefit period, the original plan is responsible for the Personal Wellness and Responsibility (POWER) Account reconciliation to determine the member's rollover amount. The original managed care entity (MCE 1) sends POWER Account Reconciliation to the state so that the new calendar year benefit period MCE (MCE 2) can be notified of the member's rollover amount. MCE 1 remains responsible for determining the amount of member rollover, as well as any amounts that must be credited back to the state. MCE 1 is only responsible for all claims with dates of service during the time they had the member enrolled in their plan (regardless of the date the claim was submitted).

MCE 1 is required to submit the POWER Account reconciliation (PRF) final rollover transfer file (FX) so that the rollover amount is provided to the state. In this way, the member's discount can be applied on the new MCE's 834. Just as with a mid-year transfer member, termination is effective for MCE 1 on the last day of the month member is ending the program, and an add record would be effective the first day of the following month if the member is transferring to MCE 2. The member is treated as terminating with MCE 1 but an add record is generated by Gainwell for MCE 2.

5.19 POWER Account Reconciliation PRF Timing – Transfer Members (IX/FX)

For a member that transferred at the end of the calendar year benefit period, Gainwell sends 834 001 to the MCE on the 834.

On day 30 after the end of the rollover calendar year benefit period, the MCE for the rollover benefit period sends Gainwell an initial rollover transfer (IX) PRF to include member rollover dollars, state rollover dollars, and discount amount (depending on if member got preventive services). Gainwell receives an inbound PRF from the MCE with the prior benefit period. If the file is successful, Gainwell sends a PRF outbound to the MCE for the current benefit period. Gainwell sends the response file indicating that the data was valid before the outbound PRF is generated. On day 31, Gainwell sends the PRF to the MCE.

At 121 calendar days after the end of the HIP calendar year benefit period, MCE 1 sends PRF - IN to Gainwell with all the final data elements (claims, preventive services, and debt). This is the final rollover transfer record type (FX). Gainwell generates the response file and sends it to MCE 1. Gainwell sends Indiana Eligibility Determination Services System (IEDSS) supplemental and IEDSS sends response file.

The type of rollover the member earned (based on status at the end of the prior benefit period) determines if an 834 change record needs to be processed.

If a member is in Healthy Indiana Plan (*HIP) Plus* on day 121 but earned a *HIP Basic* discount (prior benefit period as a *HIP Basic* member), an 834 001 change record will be generated. Rollover dates must be aligned with what is sent by IEDSS reflecting PAC adjustments for the previous *HIP Plus* segment.

If a member is in *HIP Basic* on day 121 and earned rollover discount (being *HIP Basic* in the prior benefit period), MCE 2 receives an 834 001 change record with the applicable rollover segments/corresponding rollover segments, including a *Potential Plus* loop.

If a member earned a state discount (being in *HIP Plus* or *HIP Basic* at the time of application on day 121), the member dollars are transferred on the PRF with state rollover dollars and no pay record is sent. If a member is currently *HIP Basic* and earned a *HIP Basic* discount, they will receive a *HIP Potential Plus* loop, and that is on the 834 (Gainwell to MCE). The 820 is received by MCE 2 following the next capitation cycle.

In the final step, Gainwell receives the true-up amount, member payments, and recuperates from inbound PRF for the prior benefit period. The 820 payments are processed and received by the MCE. The financial that cycle runs the second Wednesday of each month will account for true-up and amounts to be recuperated by the state.

On day 121, MCE 1 calculates claims/account usage that the member incurred (all on the PRF), and money is exchanged via the 820. MCE 2 loads PRF outbound data elements and applies rollover dollars to the new calendar year benefit period.

All rollover transfer PRF transactions must be successfully processed following the timeline provided by OMPP.

5.20 POWER Account Reconciliation File Voids (VT/VR/VX/RD)

In addition to the submission of Personal Wellness and Responsibility (POWER) Account reconciliation file (PRF) files, managed care entities (MCEs) can request void PRF transactions in case of errors. OMPP may also request that MCEs void PRF transactions. A void request must be approved by the state before being processed by the fiscal agent. The MCE must submit the PRF Void File (VN File -

PRF.VN.TPID.CCYYMMDD.DAT) and the *Void Request Template with Cover Sheet* that includes the following information to the state for review:

- Number of Voids Requested
- Indication for whether resubmissions will occur
- Detailed explanation of issue(s) that occurred causing the need for the void(s)
- Member ID
- Member Name
- Date original PRF record was submitted
- Benefit period effective and end dates
- Type of record
- MCE effective and end dates
- Detailed explanation of the reason for the void
- For voids conducted that will be resubmitted, the state also requests that the MCE provide the original value and new value for the following PRF fields:
  - Member overpayment
  - Overpayment due to rollover
  - Total rollover
  - Member debt
  - Member refund
  - State refund

The state will review the information provided. After the state approves the void request, the state makes a request of the fiscal agent to process the void transactions by sending the VN File. The fiscal agent Business Unit submits the VN File for to systems for processing using a SNOW Ticket. The systems team uses the interface to update *Core* Medicaid Management Information System *(Core*MMIS) according to the transaction type and applies the void PRF transaction type to the record.

- *Core*MMIS will generate a successfully Voided Response and load the Void Record when the following is true:
  - There is a corresponding Final Record Type for the incoming Void Record Type
  - The Final Record has not been previously Voided
  - The existing MCE matches the incoming MCE
  - All fields on the incoming file matches the existing field values and
  - The capitation status processed indicator is 'Y' indicating the PRF Final Record has already processed through capitation.
- *Core*MMIS will generate a successfully Deleted Record Response and update the existing Final Record Type to 'RD', when the following is true:
  - There is a corresponding Final Record Type for the incoming Void Record Type, and
  - The Final Record has not been previously Voided

- The existing MCE matches the incoming MCE
- All fields on the incoming file matches the existing field values and
- The capitation status processed indicator is 'N' indicating the PRF Final Record has not processed through capitation. Deleted Record 'RD' are not to be processed in the Capitation Cycle.

*Core*MMIS will provide a response file (PRF.RESP.VN.TDIP.CCYYMMDD.DAT). The PRF Void Response file will be generated after MMIS has processed the MCE PRF Void Inbound file. The PRF Void Response file will report PRF Void Record validation responses. The file name will include a timestamp. The PRF.RESP.TPID.VN.TPID.CCYYMMDD.DAT file will include the below fields:

- Record Type
- MID
- Benefit Period Begin Date
- Benefit Period End Date
- Status Message

The MCE also receives an outbound file (PRF.OUT.VN.TDIP.CCYYMMDD.DAT) once *Core*MMIS processes the voids. The outbound response file will only contain VR, VX and VP records. This file will only be generated when FX, FR, or FP records are successfully Voided or Deleted. The file name will include a timestamp.

The MCE sees the void and any payments or recoupments applied on the next financial cycle.

If the MCE is resubmitting the voided PRF, they may resubmit once the fiscal agent notifies that the void has been applied to the original transaction.

All MCE initiated void requests must be submitted no later than two months after the final PRF submission date. Any void requests received after that timeframe may not be approved. OMPP may also request MCEs to void and resubmit PRF records as part of capitation reconciliation and the timeframe for those void requests will be determined by OMPP.

5.21 POWER Account Reconciliation File 820 Capitation Process

Payments and recoupments between the managed care entity (MCE) and the state are reported on the 820 transaction file. Personal Wellness and Responsibility (POWER) Account reconciliation file (PRF) types and reason codes related to these transactions are listed in the *820 MCE Capitation Payment Information Transaction* companion guide.

The state makes an initial contribution of $1,300 to the POWER Account after the member is confirmed as fully eligible for the calendar year benefit period. The $1,300 payment comes across on the monthly POWER Account 820 capitation file. Only one $1300 contribution will be paid per member, per calendar year. If the member has more than one MCE in the benefit period, only the first MCE receives the $1300 contribution. The subsequent MCE(s) will receive the $1300 contribution as part of the true-up when they reconcile the POWER Account.

In order for subsequent MCEs to receive the $1300 initial contribution as part of the true-up, the MCEs must populate the following on PRF submissions.

- Field 12 (AMT_ST_PAC_FUND) – Populate with the numeric value of $0, provided no $1300 state contribution (SC) has been received.
- Field 15 (IND_MID_TRAN) – Populate the numeric value of 1.
- Field 25 (AMT_820) – Populate with the numeric value of $2500 minus the value in field 21 (amount member total required).

After the POWER Account is reconciled by the MCE submitting a final PRF per the timing outlined previously, the financial cycle is run, and MCE recoupments and MCE true-ups are processed.

The capitation process for POWER Accounts occurs the third Wednesday of every month. See Appendix A for assigned capitation codes specifically for POWER Account reconciliation.

MCEs must review the POWER Account capitation received on the 820 against the reconciliation submitted to ensure all capitation amounts were processed correctly. Any discrepancies in POWER Account reconciliation capitation must be reported by the MCEs to Gainwell and OMPP and reconciled no later than 2 years following the end of the benefit period.

OMPP also reviews monthly capitation reports generated by the FSSA Social Services Data Warehouse (SSDW) to identify any missing capitation adjustments. OMPP works with Gainwell and the MCEs to reconcile the missing or overpaid capitation. All POWER Account capitation must reconciled no later than 2 years following the end of the benefit period.

5.22 Missing and Duplicate Initial POWER Account Contributions

MCEs should conduct a reconciliation of the POWER Account 820 capitation payments. The MCEs should identify if they are missing the initial $1,300 POWER Account contribution. If an MCE identifies they are missing the $1,300 contribution and they are the first MCE assigned in the benefit period, the MCE needs to report that to the state's fiscal agent's Care Program Unit. The fiscal agent uses their standard operating procedures to initiate the missing payment on the next capitation cycle.

The MCEs should also identify if they received duplicate initial $1,300 POWER Account contributions. If an MCE identifies they have been overpaid, the MCE needs to report that to the state's fiscal agent's Care Programs Unit. The fiscal agent uses their standard operating procedures to initiate the recoupment of the duplicate contribution on the next capitation cycle.

All missing or overpaid initial state POWER Account contribution payments must be reported by the MCEs to Gainwell and OMPP and reconciled no later than two years following the end of the benefit period. All POWER Account correspondence for Gainwell should be sent to inxixprfteam@gainwelltechnologies.com.

5.23 POWER Account Reconciliation File MCE Reporting

There are standard Personal Wellness and Responsibility (POWER) Account reconciliation reports generated for the managed care entities (MCEs). There are four reports generated the 10th of every month by the state's fiscal agent. There are also other reports generated by FSSA Social Services Data Warehouse (SSDW). See the following table for the POWER Account reconciliation file (PRF) reporting log.

Table 19 – PRF Reporting Log/Schedule

Report	Report File Name	Report Type	Report Description	Frequency/Distribution	Distributed By	Delivery Method
PRF Monthly Overdue Report	**MGD-0208-M-PRF MONTHLY OVERDUE RPT_YYYYMMDD** MDwise = MD_OVERDUE_RPT_YYYYMMDD Anthem = AN_OVERDUE_RPT_YYYYMMDD CareSource = CA_OVERDUE_RPT_YYYYMMDD MHS = MH_OVERDUE_RPT_YYYYMMDD	Overdue PRF Report	Listing of all PRFs that are overdue based on members benefit period end date. PRFs on the report are those outstanding as of 135 days past benefit period end date.	Monthly - 10th of each month	Gainwell	File Exchange (MCEs) via DataMotion secure email (OMPP and HMA)
POWER Account Payment Report	PRF_MONTHLY_POWER_ACCT_PYMT_RPT.ANTHEM.<date>.pipe-delimited.txt PRF_MONTHLY_POWER_ACCT_PYMT_RPT.MDWISE.<date>.pipe-delimited.txt PRF_MONTHLY_POWER_ACCT_PYMT_RPT.MHS.<date>.pipe-delimited.txt PRF_MONTHLY_POWER_ACCT_PYMT_RPT.CARESOURCE.<date>.pipe-delimited.txt	PRF Power Account Report	Shows all of the POWER Account payments (SC) and recoupments (WR) made from Gainwell to the MCEs.	Monthly - 10th of each month	Gainwell	File Exchange (MCEs) via DataMotion secure email (OMPP and HMA)

Report	Report File Name	Report Type	Report Description	Frequency/Distribution	Distributed By	Delivery Method
Benefit Period Report	PRF_MONTHLY_BENEFIT_PERIOD_RPT.ANTHEM.<date>.pipe-delimited.txt PRF_MONTHLY_BENEFIT_PERIOD_RPT.MDWISE.<date>.pipe-delimited.txt PRF_MONTHLY_BENEFIT_PERIOD_RPT.MHS.<date>.pipe-delimited.txt PRF_MONTHLY_BENEFIT_PERIOD_RPT.CARESOURCE.<date>.pipe-delimited.txt	PRF Benefit Period Report	Shows all of the benefit periods that MCEs have received and should file a PRF on. This report also includes the Benefit Period and MCE Effective dates that the MCEs should use.	Monthly - 10th of each month	Gainwell	File Exchange (MCEs) via DataMotion secure email (OMPP and HMA)
PRF Transfer Report	PRF_MONTHLY_TRANSFER_RPT.ANTHEM.<date>.pipe-delimited.txt PRF_MONTHLY_TRANSFER_RPT.MDWISE.<date>.pipe-delimited.txt PRF_MONTHLY_TRANSFER_RPT.MHS.<date>.pipe-delimited.txt PRF_MONTHLY_TRANSFER_RPT.CARESOURCE.<date>.pipe-delimited.txt	HIP PRF Transfer Report	This report shows the transfer PRFs that are due from each of the MCEs.	Monthly - 10th of each month	Gainwell	File Exchange (MCEs) via DataMotion secure email (OMPP and HMA)
PRF Submission Tracking Reports	PRF Submission Tracking - Trends by PRF Type PRF Submission Tracking - Trends by MCE Type PRF Submission Summary	Tracking of PRF Reconciliations Submitted	These reports provide the OMPP with a report of the PRF Reconciliations submitted by the MCEs from week to week for a specific benefit period. The reports are broken out by MCE and by PRF type. The reports indicate the total number of PRFs due, total number submitted to date, total new submitted the last week, total overdue and percent submitted. The Submission Tracking is also shared with the MCEs so they can monitor their progress on submissions.	Weekly	SSDW OMPP (to MCEs)	Email and HIP Dashboard Email (to MCEs)

Report	Report File Name	Report Type	Report Description	Frequency/Distribution	Distributed By	Delivery Method
PRF Rollover Summary	PRF Rollover Summary	Rollover Summary for Current Benefit Period Reconciliations	This report provides a summary of the data submitted on rollover PRF transactions for the current benefit period. It gives the number of Rollover transactions submitted and breaks out how many members earned rollover, members who used zero POWER Account dollars, number exhausted their POWER Account dollars, the average POWER Account expenditure, number earned state rollover, number earned a discount, and so forth.	Weekly	SSDW	Email and HIP Dashboard
State Contribution Report (SC) - POWER Account Payments ($1300)	SC YYYY - MMDDYYYY	State POWER Account Capitation Report	Report that identifies for a benefit period if there are missing $1300 POWER Account payments, overpayments of POWER Account payments, or POWER Account payments made to wrong MCEs. Report is pulled using the eligibility data and 820 "SC" capitation payment data.	Monthly - Following capitation cycle (requested)	SSDW	Email

Report	Report File Name	Report Type	Report Description	Frequency/Distribution	Distributed By	Delivery Method
PRF Capitation Reports	MP YYYY - As of MMDDYYYY RM YYYY - As of MMDDYYYY RZ YYYY - As of MMDDYYYY SC YYYY - As of MMDDYYYY SR YYYY - As of MMDDYYYY SS YYYY - As of MMDDYYYY TR YYYY - As of MMDDYYYY TU YYYY - As of MMDDYYYY	PRF Capitation Reconciliation Report	Reports identify where the amounts listed on a PRF transaction do and do not match what was paid in the 820 financial capitation cycle. There is a report by POWER Account related capitation codes (MP - Member Penalty, RM - Member Rollover Recoupment, RZ - Prior Year Unused State Dollars, SR - State Rollover to Receiving Plan, SS - Member Rollover Payout, TR - Termination Recoupment, and TU - True Up).	Monthly - Following capitation cycle (requested)	SSDW	Email
PRF Summary Report	PRF Reconciliation Summary - Termination_YYYYMMDD PRF Reconciliation Summary - Rollover_YYYYMMDD PRF Reconciliation Summary - Transfer_YYYYMMDD	Summary for Current Benefit Period Reconciliations	These reports provide a summary of the data submitted on term, rollover and transfer PRF transactions for the current benefit period. It gives by length of enrollment: count of members; count that expended POWER account and percent; average account balance; count of refunds to the state, total dollars and average dollars refunded; count of, total dollars and average dollars refunded to members; number of 25% penalties applied and average amount	Weekly	SSDW	Email and HIP Dashboard

Report	Report File Name	Report Type	Report Description	Frequency/Distribution	Distributed By	Delivery Method
			of penalty; and count of members with debt and the average debt amount.			
Plan Change Report	MCE – Plan Changes_YYYY	Report listing of members that changed plans during the Benefit Period.	This report provides the MCE with a list of HIP members that changed MCEs during the calendar year benefit period. The members had another MCE first in the benefit period so this report tells the second MCE to reconcile the PRF as a transfer to receive the initial $1300 state contribution as part of true-up.	As requested by OMPP. Generated at the onset of PRF reconciliations.	SSDW	Email

Section 6: Covered Benefits and Services

This section provides information about the services that are covered and excluded from the various programs covered by the Healthy Indiana Plan (HIP). Information is also included about in-network versus out-of-network services and self-referral services.

Continuity of care is very important to member outcomes. This section also includes information about members who may need to transfer to another program.

6.1 Healthy Indiana Plan Covered Services

The following benefits and services are eligible for coverage under HIP. Pursuant to state regulation *405 IAC 10* and the *HIP Basic* and *HIP Plus Alternative Benefit Plans* detailed in the federal special terms and conditions waiver, these benefits and services must be covered by the managed care entity (MCE) if they are medically necessary, not listed as a noncovered benefit or service, or otherwise excluded from coverage. *HIP Basic and HIP Plus* benefits are covered in Table 22 and *HIP State Plan Plus* and *State Plan Basic* benefits are covered in Table 20.

Table 20 – HIP Basic and HIP Plus Covered Benefits

Benefit	Description of Amount, Duration, and Scope		Reference
	***HIP Basic* Plan (MARB)**	***HIP Plus* Plan (MARP)**	
Essential Health Benefits (EHB) Category: Ambulatory Patient Services			
Primary Care Physician Services[1]	Covered Service		*1905(a)(5*)
Specialty Physician Visits	Covered Service		*1905(a)(5)*
Home Health Services	Covered Service. 100 visits per year	Covered Service. 100 visits per year	*1905(a)(7)*
Chiropractic Care	Not Covered	Covered Service. Limited. 6 spinal manipulations per year	*1905(a)(6)*
Outpatient Surgery	Covered Service		*1905(a)(2)*
TMJ	Not Covered	Covered Service	
Allergy Testing	Covered Service		*1905(a)(13)*
Chemotherapy	Covered Service		
IV Infusion Services	Covered Service		
Radiation Therapy	Covered Service		
Dialysis	Covered Service		

[1] *Includes advanced practice registered nurse practitioners (APRNs).*

Benefit	Description of Amount, Duration, and Scope		Reference
	***HIP Basic* Plan (MARB)**	***HIP Plus* Plan (MARP)**	
Routine Dental Services	Not Covered except for EPSDT	Covered Service. Limited to basic commercial package	*2105(c)(5)*
Routine Vision Services	Not Covered, except for EPSDT	Covered Service	*1905(a)(6)*
EHB Category: Emergency Services			
Emergency Department Services	Covered Service. Nonemergency visits to the emergency department subject to $8 copay		*1905(a)(29)*
Emergency Transportation: Ambulance and Air Ambulance	Covered Service		
Urgent Care/Emergency Clinics (non-hospital facilities)	Covered Service		
EHB Category: Hospitalization			
General Inpatient Hospital Care	Covered Service		*1905(a)(1)*
Inpatient Physician Services	Covered Service		*1905(a)(1)*
Inpatient Surgical Services	Covered Service		*1905(a)(1)*
Non-Cosmetic Reconstructive Surgery	Covered Service		*1905(a)(1)*
Transplants	Covered Service		*1905(a)(1)*
Congenital Abnormalities Correction	Covered Service		*1905(a)(1)*
Anesthesia	Covered Service		*1905(a)(1)*
Hospice Care	Covered Service		*1905(a)(18)*
Skilled Nursing Facility	Covered Service. Limited to 100 days	Covered Service. Limited to 100 days	*1905(a)(4)*
EHB Category: Mental Health and Substance Abuse			
Mental/Behavioral Health Inpatient Treatment	Covered Service		*1905(a)(1)*
Mental/Behavioral Health Outpatient Treatment	Covered Service		*1905(a)(2)*

Benefit	Description of Amount, Duration, and Scope		Reference
	***HIP Basic* Plan (MARB)**	***HIP Plus* Plan (MARP)**	
Substance Abuse Inpatient Treatment	Covered Service		*1905(a)(1)*
Substance Abuse Outpatient Treatment	Covered Service		*1905(a)(2)*
EHB Category: Prescription Drugs			
Prescription Drugs	Covered Service		*1905(a)(12)*
Tobacco cessation drugs	Covered Service		
EHB Category: Rehabilitative and Habilitative Services and Devices			
Physical Therapy, Occupational Therapy, Speech Therapy[2]	Covered Service. Limited to 60 combined visits	Covered Service. Limited to 75 combined visits	*1905(a)(11), 1905(a)(13)*
Durable Medical Equipment	Covered Service		*1905(a)(29)*
Prosthetics	Covered Service		*1905(a)(12)*
EHB Category: Laboratory			
Lab Tests	Covered Service		*1905(a)(3)*
X-Rays	Covered Service		*1905(a)(3)*
Imaging – MRI, CT, and PET	Covered Service		*1905(a)(3)*
Pathology	Covered Service		*1905(a)(13)*
EHB Category: Preventive Care			
Preventive Care Services	Covered Service. Limited to ACA required preventive services[3]		*1905(a)(13)*
Other Benefits			
Non-Emergency Transportation	Not Covered	Not Covered	*1905(a)(10)*
EPSDT for Ages 19 & 20 Only	Covered Service		
Bariatric Surgery	Not Covered	Covered Service	*1905(a)(1)*

[2] Chiropractors are included in approved providers for physical and occupational therapy services.
[3] Includes services with an "A" or "B" rating from the United States Preventive Task Force, immunizations recommended by the Centers for Disease Control and Prevention, and additional preventive care screenings for women as provided in the Health Resources and Services Administration guidelines.

Benefit	Description of Amount, Duration, and Scope		Reference
	***HIP Basic* Plan (MARB)**	***HIP Plus* Plan (MARP)**	
Long-Term Care	Not Covered	Not Covered	*1905(a)(4)*
MRO	Not Covered	Not Covered	
Hearing Aids	Covered Service		*1905(a)(29)*
Obstetric Care	Covered Service		*1905(a)*
Smoking Cessation 12-week Course	Covered Service		*1937*

Table 21 – HIP State Plan and HIP Maternity Covered Benefits

Benefit	Description of Amount, Duration, and Scope	Reference
	HIP State Plan (MASP) and HIP Maternity (MAMA)	
Essential Health Benefits (EHB) Category: Ambulatory Patient Services		
Primary Care Physician Services[4]	Covered Service	*1931*
Specialty Physician Visits	Covered Service	*1931*
Home Health Services	Covered Service. No limits	*1931*
Chiropractic Care	Covered Service. 50 units per year	*1931*
Outpatient Surgery	Covered Service	*1931*
TMJ	Covered Service	*1931*
Allergy Testing	Covered Service	*1931*
Chemotherapy	Covered Service	*1931*
IV Infusion Services	Covered Service	*1931*
Radiation Therapy	Covered Service	*1931*
Dialysis	Covered Service	*1931*
Dental Services	Covered Service	*1931*
Vision Services	Covered Service	*1931*

[4] *Includes advanced practice registered nurse practitioners (APRNs).*

Benefit	Description of Amount, Duration, and Scope	Reference
	HIP State Plan (MASP) and HIP Maternity (MAMA)	
EHB Category: Hospitalization		
General Inpatient Hospital Care	Covered Service	*1931*
Inpatient Physician Services	Covered Service	*1931*
Inpatient Surgical Services	Covered Service	*1931*
Non-Cosmetic Reconstructive Surgery	Covered Service	*1931*
Transplants	Covered Service	*1931*
Congenital Abnormalities Correction	Covered Service	*1931*
Anesthesia	Covered Service	*1931*
Hospice Care	Covered Service	*1931*
Skilled Nursing Facility	Covered Service	*1931*
EHB Category: Mental Health and Substance Abuse		
Mental/Behavioral Health Inpatient Treatment	Covered Service	*1931*
Mental/Behavioral Health Outpatient Treatment	Covered Service	*1931*
Substance Abuse Inpatient Treatment	Covered Service	*1931*
Substance Abuse Outpatient Treatment	Covered Service	*1931*
EHB Category: Prescription Drugs		
Prescription Drugs	Covered Service	*1931*
Tobacco Cessation Drugs	Covered Service	*1931*
EHB Category: Rehabilitative and Habilitative Services and Devices		
Physical Therapy, Occupational Therapy, Speech Therapy[5]	Covered Service. 12 visits every 30 days without Prior Authorization	*1931*
Durable Medical Equipment	Covered Service	*1931*

[5] *Chiropractors are included in approved providers for physical and occupational therapy services.*

Benefit	Description of Amount, Duration, and Scope	Reference
	HIP State Plan (MASP) and HIP Maternity (MAMA)	
Prosthetics	Covered Service	*1931*
EHB Category: Laboratory		
Lab Tests	Covered Service	*1931*
X-Rays	Covered Service	*1931*
Imaging – MRI, CT, and PET	Covered Service	*1931*
Pathology	Covered Service	*1931*
EHB Category: Preventive Care		
Preventive Care Services	Covered Service	*1931*
Other Benefits		
Non-Emergency Transportation	Covered Service	*1931*
EPSDT for Ages 19 & 20 Only	Covered Service	
Bariatric Surgery	Covered Service	*1931*
Long-Term Care	Covered Service	*1931*
MRO	Covered Service	*1931*
Hearing Aids	Covered Service	*1931*
Obstetric Care	Covered Service	*1905(a)*
Smoking Cessation 12-week Course	Covered Service	*1937*

Table 22 – HIP Excluded Benefits

Benefit	Description of Amount, Duration, and Scope	Reference
Acupuncture	Not Covered	*1905(a)(29)*
Infertility Diagnoses and Treatment	Not Covered	*1905(a)(29)*
Residential Services	Not Covered	*1905(a)(29)*
Other	Any other services not covered by the medical assistance program	*1905(a)(29)*

Coverage of the benefits and services is subject to the coverage criteria, limitations, and procedures specified in *405 IAC 10*, in these policies and procedures, and in manuals, bulletins, or other documentation

issued by the MCEs or the state. (See *405 IAC 10*). The MCE's member and provider handbooks and websites must detail the coverage criteria, limitations, and procedures of its HIP plan.

6.2 Self-Referral Services

The MCE must include providers of self-referral services in its contracted network. The MCE and its PMPs may direct members to seek self-referral services from providers contracted in the MCE's network; however, except for behavioral health (nonpsychiatric) and routine dental services (if covered by member plan), the MCE cannot require members to use MCE-network providers.

With the exception of family planning services and emergency or urgent care services, when HIP members choose to receive self-referral services from self-referral providers that are not contracted with the MCE, the MCE is responsible for payment of self-referral services up to the applicable benefit limits and at a rate not less than the state-directed minimum fee schedule established by the state.

The following services are considered self-referral services, in that they do not require a PMP referral. Self-referral limitations are indicated for each type of service:

1. Emergency services (any provider; requires IHCP enrollment to facilitate payment)
2. Urgent care services (any IHCP-enrolled provider)
3. Family planning (any IHCP-enrolled provider)
4. Immunizations (any IHCP-enrolled provider)
5. Podiatry (any IHCP-enrolled provider)
6. Psychiatric services (any IHCP-enrolled provider)
7. Eye care (except surgery) (any IHCP-enrolled provider; subject to benefit plan coverage)
8. Diabetes self-management services (any IHCP-enrolled provider subject to MCE PA requirements)
9. Chiropractic services (any IHCP-enrolled provider subject to MCE PA requirements; subject to benefit plan coverage)
10. Behavioral health (nonpsychiatric) (any MCE network provider)
11. Dental (routine) (any MCE network provider; subject to benefit plan coverage)

The Indiana Administrative Code *405 IAC 9-7* provides further detail about the self-referral 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 1-1*. Non-MCE-network providers are subject to MCE PA requirements. Chiropractic services may only be provided to members receiving services through *HIP State Plan*, *HIP Plus* or while receiving the additional HIP pregnancy-only benefits.
* 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 *HIP State Plan*, *HIP Plus*, or while receiving the additional HIP pregnancy-only benefits.
* Routine dental services may be provided by any in-MCE-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 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*. Podiatry services are covered for members receiving services through *HIP State Plan* only.

* 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 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. The Contractor 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 and treatment. 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 *Family Planning Services* provider reference module provides a complete and current list of family planning services.
    a. 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 be certified by a physician, place the woman in danger of death unless an abortion is performed and in compliance with 42 CFR 441.202.
* The *Family Planning Services* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers provides a complete and current list of family planning services. Under the MCE's HIP line of business, the MCE must provide all covered family planning services and supplies.
* Emergency services are covered without the need for prior authorization or the existence of an MCE contract with the emergency care provider. Emergency services must be available 24 hours a day, 7 days a week, subject to the *prudent layperson* standard of an emergency medical condition, as defined in *42 CFR 438.114* and *IC 12-15-12*.
* Urgent care services.
* Immunizations are self-referred to any IHCP-enrolled provider and are covered regardless of where they are received.
* Diabetes self-management services are covered if rendered by any IHCP-enrolled provider authorized to render these services. Non-MCE-network providers are subject to MCE PA requirements.
* Behavioral health services are self-referred if rendered by an in-network provider. Members may self-refer, within the MCE'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. The mental health providers to which the member may self-refer within network are:

- Outpatient mental health clinics
- Community mental health centers
- Psychologists
- Certified psychologists
- Health service provider in psychology (HSPP)
- Certified social workers

- Certified clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses under *IC 25-23-1-1(b)(3)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Persons holding a master's degree in social work, marital and family therapy, or mental health counseling (under the Clinic Option)

6.3 Chiropractic Services

Each HIP benefit plan has a set limit of chiropractic service units per year. Each individual physical medicine treatment and therapy, office visit, or manipulation Current Procedural Terminology (CPT®1) code counts as 1 unit toward a plan's limit. Multiple chiropractic manipulations or physical medicine treatments can be billed in a single day, but each would count separately toward the plan's limit.

Managed care entities (MCEs) may require prior authorization (PA) to determine whether services available on the chiropractic code set are medically necessary. The designation of services performed by chiropractors as self-referral does not prohibit an MCE from requiring PA to determine medical necessity. The chiropractic code set can be found in Chiropractic Services Codes, accessible from the Code Sets page at in.gov/medicaid/providers.

6.3.1 HIP Basic

HIP Basic does not cover chiropractic manipulation services (procedure codes 98940–98943). *HIP Basic* covers a combined annual total of 60 units for the following services:

* Physical therapy
* Occupational therapy
* Speech therapy
* Rehabilitation

Chiropractors can perform rehabilitation and habilitation-related physical medicine treatments and therapies. Physical medicine treatments and therapies as well as office visits on the chiropractic code set that are for rehabilitation count toward the 60-unit limit. Manipulations cannot count toward this limit. Radiology, laboratory, diabetic education, and community health worker services on the chiropractic code set do not count toward this limit.

The following chiropractic codes apply to the physical therapy, occupational therapy, speech therapy, and rehabilitation limit:

* Physical medicine treatments and therapies (procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032–97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140)
* Office visits (procedure codes 99202–99203, 99211–99213)

6.4 Preventive Services

HIP preventive services may be updated yearly by October 1, and any age- and gender-appropriate preventive service can be obtained to qualify a member for rollover to apply for the member's following year's POWER Account contribution. The MCE must send preventive service reminders to its members

throughout the benefit period, including in the monthly POWER Account statements and redetermination correspondence.

The MCE must have mechanisms in place to monitor when a member has obtained the preventive care services recommended for their age and gender, as well as pre-existing conditions, and report this information on the POWER Account reconciliation file (PRF) 121 calendar days following the end of the member's benefit period.

The MCE must monitor whether a member has received recommended preventive care services by:

1. Using claims data to determine if any of the certain specified disease conditions exist.
2. Using claims data to determine if one required preventive service has been obtained (the state must provide the qualifying CPT and ICD codes).
3. Receiving verification from the member that he or she obtained one preventive service.

Ninety calendar days before the end of a member's predefined benefit period, the MCE must make an initial assessment of whether the member has completed a recommended preventive service. If the member has not received recommended preventive services, the MCE must send a reminder to the member. The reminder must notify the member that the MCE's records indicate that the member has not received any 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 must also explain that if the member receives the recommended preventive service, the member is eligible to roll over the entire remaining POWER Account balance at the end of the benefit period, including the state's contribution. This correspondence must be coordinated with the other redetermination reminders and provided no later than 60 calendar days before the end of the member's benefit period.

Sixty (60) calendar days after the end of the member's benefit period, the MCE must make an assessment (through claims and other information, as described previously) to determine if the member has completed the recommended preventive service. The MCE must send a letter to the member informing him or her of the assessment's outcome. This letter must go out within the 60-calendar day period. The following criteria must be considered for this letter:

4. The letter to the member does not need to spell out what services the member received and what was not received. The letter must indicate only that a qualifying preventive care service was not completed.
5. The letter to the member must list what the qualifying 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.
6. The MCE must develop a form that can be easily completed by a member's physician, which verifies that a service appropriate for the member's age and sex have been obtained. This form must be included in the letter to the member.
7. If the MCE's records indicated that the member has not received the recommended preventive services, then the MCE must allow the member to file a grievance on the decision by submitting documentation that indicates that the member did in fact receive qualifying preventive care. The form included in the member's letter can be used as supporting documentation but must be completed by the member's physician.
8. The letter must indicate that the member has 60 calendar days from receipt of the letter to file a grievance on the decision and submit additional information using the attached form. The MCE may incorporate this grievance process into its existing grievance and appeals process but must ensure that the grievance is resolved in a time period that allows for timely submission of a complete and accurate PRF to the state.
9. If a member changes MCEs during redetermination, then the MCE (for example, original MCE) is responsible for sending the letter and giving the member an opportunity to file a grievance.

Example language that must be included in the letter to the member includes:

10. The required preventive services for the year were **X.**

    - For *HIP Plus* members: Because you regularly contributed to your POWER Account throughout the year, you are eligible to roll over your unused share of the remaining POWER Account balance. If you also received a qualifying preventive service, your "rollover amount" is doubled by the state to further reduce the cost of the plan in the next benefit period.

    - For *HIP Basic* members: If you received a qualifying preventive service, you are eligible to receive a discount on the required monthly POWER Account contributions if you choose to participate in *HIP Plus* in the next benefit period. The discount is based on a percentage of your remaining POWER Account balance at the end of your current benefit period.

11. A preliminary review of our records indicates that you have not received a qualifying preventive service.

12. If you believe our preliminary determination is in error and you have received the preventive service listed previously, please fill out the attached form and submit it to **X**. The form must be filled out by your physician and returned within 30 calendar days.

Preventive services mandated by the *Affordable Care Act (ACA)* include "A" and "B" services recommended by the United States Preventive Services Task Force (USPSTF) Advisory Committee on Immunization Practices (ACIP)-recommended vaccines; preventive care and screening for infants, children, and adults recommended by Health Resources and Services Administration's (HRSA's) Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM), are provided as first dollar coverage and are not paid out of the POWER Account. HIP members have no cost-sharing on preventive services. For preventive services other than those mandated by the ACA, the first $500 in claims for covered preventive care services to members at no cost. This is referred to as *$500 of first dollar coverage* for preventive care services because it is not subject to the annual deductible. The POWER Account funds must not be used to pay for the first $500 of non-ACA mandated preventive care services. Additional preventive care services received by members that are outside of the ACA mandate are subject to the deductible unless the MCE chooses to offer a more generous preventive care services benefit.

The USPSTF preventive services qualify for exemption from payment from *HIP Basic*, *HIP Plus*, *HIP State Plan Plus,* and *HIP State Plan Basic Member* POWER Accounts (payment is subject to HIP benefits).

To view procedure codes that qualify as preventive services for HIP members, see the provider code table document called, *Preventive Care Services Excluded from Copayment for Healthy Indiana Plan and Presumptive Eligibility – Adult*, accessible from the Code Sets page at in.gov.medicaid/providers.

> ***Note:*** *HIP members who are subject to copayments, the preventive service procedure codes in that table are exempt from copayment requirements when billed as indicated. Those services are also not deducted from Personal Wellness and Responsibility (POWER) Accounts for members in HIP Plus, HIP State Plan Plus, HIP State Plan Basic, and HIP Maternity.*

6.5 Short-Term Placements in Long-Term Care Facilities

MCEs may allow their enrolled members to receive services in a long-term care (LTC) facility on a short-term basis (up to 30 days) if this setting is more cost-effective than other options, and if the member can obtain the care and services needed.

The MCE is financially responsible for short-term placement fees made to the nursing facility at the state-directed minimum fee schedule established by the state. See the following section for MCE responsibility after 30 days.

6.6 Pending Level-of-Care Determination

When a patient is admitted to or screened at an LTC facility, such as a nursing facility, community residential facility for the developmentally disabled (CRF/DD), or an intermediate care facility for individuals with intellectual disability (ICF/IID), the LTC provider must verify the patient's IHCP eligibility and healthcare program to determine whether the individual is enrolled in a managed care program. The LTC provider must contact the managed care plan responsible for the patient's care.

- When a managed care member is undergoing screening for admission to an IHCP-certified LTC or nursing facility, the facility must complete the level-of-care (LOC) paperwork and submit it to the appropriate agency. It is not until the LOC determination is entered into *Core*MMIS that managed care enrollment is blocked or managed care disenrollment occurs. Additional information can be found in the *Long-Term Care* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers

If the facility determines that a patient is enrolled with an MCE, then the provider must notify the MCE within 72 hours. If the provider fails to verify an IHCP member's coverage or fails to contact the MCE within 72 hours of admission, then the provider is responsible for any charges incurred until the member is disenrolled from the MCE. When the provider notifies the MCE within 72 hours of admission, the MCE is liable for charges up to 100 days from the date of admission.

If the provider fails to complete the paperwork for the appropriate LOC determination, and the member is still enrolled in HIP after 100 days, the MCE is no longer liable for payment. However, as long as the patient is a member of the MCE, claims submitted to the state fiscal agent are denied payment. If the individual needs ongoing skilled nursing facility care (such as longer than 00 days), then a pre-admission screening must be completed, and the continued stay must be authorized by the local Area Agency on Aging (AAA) before the 60th day. If a member is approved for long-term nursing facility placement by the AAA, then the long-term services are not covered by the MCE. For long-term stays, the nursing facility must complete the *Physician Certification of Long-Term Care Service Form 450B*.

A member approved for long-term nursing facility placement is disenrolled from HIP and converted to FFS eligibility in the IHCP when the appropriate LOC information is entered in *Core*MMIS. The MCE plays a critical role in monitoring its members who receive care in nursing facilities and helping coordinate the transition to long-term care.

6.7 Early and Periodic Screening, Diagnosis, and Treatment Services

EPSDT is a federally mandated preventive healthcare program designed to improve the overall health of Medicaid-eligible infants, children, and adolescents from birth to 21 years old.

EPSDT/HealthWatch is the name of Indiana's EPSDT program. EPSDT/HealthWatch services are available for all HIP members under age 21. EPSDT/HealthWatch 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 21 years old in institutions of mental disease (IMDs).

The primary goal of HealthWatch is to ensure that children enrolled in the IHCP receive age-appropriate comprehensive, preventive services. Early detection and treatment can reduce the risk of costlier treatment or hospitalization resulting from delayed treatment. Additional information can be found in the *Early and*

Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers.

The MCE must cover lead screening and hearing aids for 19- and 20-year-old HIP members. Lead screening services are a preventive service and are not subject to the $2,500 deductible.

6.7.1 Early and Periodic Screening, Diagnosis, and Treatment Program

The federally established EPSDT program, known as HealthWatch in Indiana, is part of the IHCP and was established in 1967. The HealthWatch program is a children's preventive healthcare program providing initial and periodic examinations and medically necessary follow-up care. The program objectives are to improve the overall health of infants, children, and adolescents through early detection and treatment of medical conditions. These efforts can reduce the risk of costlier treatment or hospitalization that can occur when detection of medical problems is delayed.

This program is available on a voluntary basis to eligible children from birth through 20 years. Any medical provider enrolled in the IHCP is eligible to offer HealthWatch screenings for IHCP-enrolled infants, children, and adolescents. Medical providers can offer EPSDT services to new and existing IHCP patients.

To meet standards for preventive child healthcare, the state requires adherence to guidelines developed by the AAP. The AAP publishes a schedule of recommendations for screening components, screening frequency, and immunizations started in infancy. For additional information, see the HealthWatch Recommended Screening Techniques and Referral Standards in the *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch* provider reference module on the Provider Reference Materials page at in.gov/medicaid/providers.

MCEs are responsible for ensuring that members receive EPSDT services. The state conducts ongoing studies for this focus area to measure results and monitor MCE compliance. MCEs are required to report EPSDT compliance through submission of encounter data, as described in *Information Systems*.

6.8 Pharmacy Benefits

Prescription drugs are a benefit under the HIP program to be covered by the MCE. The MCE shall support the Family and Social Services Administration (FSSA) in promptly responding to public and legislative inquiries involving the design and management of the MCE's pharmacy benefit. If the MCE elects to subcontract with a pharmacy benefits manager (PBM), then the MCE must ensure compliance with all subcontracting requirements as described in the contract between the state and the MCE, including but not limited to conducting regular audits and monitoring of the subcontractor's data and performance, as well as requiring their PBM to conduct regular audits of their pharmacy provider networks.

6.8.1 Drug Rebates

The MCE shall ensure compliance with the requirements under *Section 1927* of the *Social Security Act*. In accordance with the ACA, 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, the FSSA must include utilization data of MCEs when requesting quarterly rebates from manufacturers as well as in quarterly utilization reports to the CMS. Thus, the MCE shall submit their pharmacy encounter data to the state, in a manner required by the state. The MCE shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of paid amounts. The state intends to use and share the MCE paid amount information on the

state's pharmacy claim extracts for rebate purposes. Requirements for pharmacy encounter claims are outlined in Section 24.

These files 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 MCE members and such other data that the Secretary of the CMS determines necessary for the state to access rebates. This reporting shall include physician-administered drugs and other drugs billed on a *CMS-1500* or *UB-04 claim* form.

Additionally, the MCE shall assist the FSSA or the state's PBM contractor in resolving drug rebate disputes with the manufacturer.

6.8.2 HIP Preferred Drug List and Formulary Requirements

The MCE shall maintain a distinct preferred drug list (PDL) for the MCE's *HIP State Plan* package, as well as one distinct formulary applicable to the MCE's *HIP Plus* and *HIP Basic* packages. In establishing its HIP formulary, the MCE shall ensure that the prescription drug benefit 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. Further, the HIP formulary must support the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in *405 IAC 5-24-3*. The MCE must ensure that non-drug products approved for use in compounding are not subject to rebating manufacturer requirements.

While the underlying drug formulary for the *HIP Plus* and the *HIP Basic* plans are identical, additional pharmacy services will differ between the plans to align the benefits with the overall program goals aimed at encouraging member participation in *HIP Plus*. Therefore, the *HIP Basic* pharmacy benefit is more restrictive than *HIP Plus*, as it only offers members access to brand name drugs through either step therapy or prior authorization, and the prescription supply is limited to 30 days. Also, prescriptions obtained by a *HIP Basic* or *HIP State Plan Basic* member that are not otherwise exempt on the basis of being preventive, family planning, or maternity, are subject to member copayment requirements. Copayments assessed to the *HIP Basic* or *HIP State Plan Basic* member at the point of sale may not exceed the usual and customary charge for the drug.

Similarly, the *HIP Plus* pharmacy benefit must provide additional enhanced pharmacy services including the following:

* Greater access to many brand-name drugs, without prior authorization requirements
* Ninety-day prescription supplies of routine maintenance medications, when requested by the member
* Mail order pharmacy benefit
* Medication Therapy Management (MTM) Services, and
* No copayment for any filled prescription

These additional pharmacy services shall only be made available to individuals participating in *HIP Plus* and *HIP State Plan Plus* benefits.

Before implementing a PDL or formulary, the MCE must:

* Submit the PDL or formulary to the FSSA for submission to the Drug Utilization Review (DUR) Board, and
* Receive approval from the FSSA in accordance with IC 12-15-35-46.

At least 35 days before the intended implementation date of the PDL and formulary, the MCE shall submit its proposed PDL and formulary to the FSSA. The FSSA shall submit the PDL and formulary to the DUR Board for review and recommendation. The MCE shall be accessible to the DUR Board to respond to any questions regarding the PDL and formulary. The DUR Board will provide a recommendation regarding

approval of the PDL and formulary in accordance with the terms of *IC 12-15-35-46*. The FSSA will approve, disapprove, or modify the PDL and/or formulary based on the DUR Board's recommendation. The MCE shall comply with the decision within 60 days after receiving notice of the decision.

The MCE shall use a Pharmacy and Therapeutics Committee which shall meet regularly to make recommendations for changes to the PDL and/or formulary. In accordance with *IC 12-15-35-47*, before removing one or more drugs from the PDL and/or formulary or otherwise placing new restrictions on one or more drugs, the MCE shall submit the proposed change to the FSSA, which shall forward the proposal to the DUR Board. Such changes shall be submitted at least 35 calendar days in advance of the proposed change. The MCE shall also meet with the FSSA staff, as directed by the FSSA, to answer questions about the clinical rationale for the proposed change. The DUR Board will provide a recommendation regarding approval of the proposed change to the PDL and/or formulary in accordance with the terms of *IC 12-15-35-47*. The FSSA will approve, disapprove, or modify the PDL and/or formulary based on the DUR Board's recommendation. The MCE is not required to seek approval from the state to add a drug to the PDL or formulary; however, the MCE shall notify the FSSA of any addition to the PDL and/or formulary within 30 days after making the addition.

The PDL and formulary shall be made readily available to providers in the MCE's network and to members. The PDL and formulary shall be updated to reflect all changes in the status of a drug or addition of new drugs. The MCE shall also support e-prescribing technologies to communicate the PDL and formulary to prescribers through electronic medical records (EMRs) and e-prescribing applications. See *E-Prescribing Section* below for additional requirements on e-prescribing. The MCE shall develop provider education and outreach aimed at educating providers about the HIP PDL and formulary as well as the utilization of e-prescribing technologies to ensure appropriate prescribing for members based on the member's benefit plan.

The MCE may opt to use the state's PDL for its *HIP State Plan* pharmacy benefits and to contract with the state's PBM contractor for *HIP State Plan* pharmacy claims processing. If the MCE takes this approach, then the MCE shall be permitted to use the work of the Therapeutics Committee and DUR Board in maintaining the state's PDL for the MCE's *HIP State Plan* benefits.

6.8.3 Individual Carved Out Drugs

The FSSA carved out select individual drugs from the MCE pharmacy benefit program. These drugs will be managed and processed by the FSSA. MCEs must make accommodations to direct claims for these drugs to the FSSA.

Prescriptions for the following medications are carved out from the pharmacy benefit program:

- Hepatitis C drugs (GPI 125350 or 123599)
- Hemophilia Agents (GPI 8510)
- Spinal Muscular Atrophy Treatments (GPI 7470)
- Muscular Dystrophy Treatments (GPI 7460)
- CAR-T Therapies (GPI 21651010 and 21651075)
- Durable Genetic Therapy (GPI 8637)
- Cystic Fibrosis Agents (GPI 453020 and 453099)
- Sickle Cell Agents (GPI 828050 and 828070)
- FDA approved SARS Coronavirus Vaccine and administration

6.8.4 DUR Board Reporting Requirements

In accordance with *IC 12-15-35-48*, the DUR Board shall review the prescription drug programs of the MCE at least one time per year. This review shall include, but is not limited to, review of the following:

- An analysis of the single source drugs requiring prior authorization in comparison to other MCEs' 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
- A review of the number of requests an MCE 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 12-month period

The MCE shall provide the FSSA with the information necessary for the DUR Board to conduct this review in the timeframe and format specified by the FSSA. In addition to the DUR Board approval, the MCE must also seek the advice of the Mental Health Medicaid Quality Advisory Committee, as required in *IC 12-15-35.5*, before implementing a restriction on a mental health drug described in *IC 12-15-35.5-3(b)*.

The MCE shall comply with any additional reporting requests required for submission to the DUR Board. See the *MCE Reporting Manual* for more information on pharmacy reporting requirements.

6.8.5 Dispensing and Monitoring Requirements

The MCE shall administer pharmacy benefits in accordance with all applicable state and federal laws and regulations. The MCE shall comply with the requirements of *IC 12-15-35.5-3* in establishing prescribing limits to mental health drugs. For any drugs that require prior authorization, the MCE shall provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization. Additionally, the MCE shall provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation as required under *42 U.S.C 1396r-8(d)(5)(B*). The MCE must employ an automated system for approval of a 72-hour emergency supply of a restricted drug. The automated system must allow the pharmacist to dispense the 72-hour supply and then follow up with the MCE or provider the next business day.

The MCE may require prior authorization requirements, such as general member information, justification for drug related to the medical needs of the member and a planned course of treatment, if applicable, as related to the number of drugs provided and duration of treatment. The MCE is required to have a process in place to provide the member drugs that are medically necessary but not included on the formulary.

The MCE shall provide online and real-time rules-based point-of-sale (POS) claims processing for pharmacy benefits. The MCE shall maintain prospective drug utilization review edits and apply these edits at the POS.

Additionally, the MCE 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.

Administration of all criteria shall be performed by the MCE or its subcontracted PBM. The MCE shall regularly report findings on audits performed and outcomes completed by the PBM about providers as follows:

- The MCE shall regularly report findings on audits performed and outcomes completed by the MCE on its contracted PBM and by its PBM about pharmacy providers.

- The MCE shall immediately report to the OMPP claims processing outages experienced by the MCE and/or its PBM within 1 hour.
- The MCE shall provide a root cause analysis of the outage to the OMPP within 10 calendar days. Root cause analyses of any noncompliance issues are to be submitted within 10 calendar days of resolution.
- The MCE shall provide a root cause analysis of the claims processing error to the office in a timely manner.

The MCE shall monitor their PBM and report to the OMPP when the PBM does not meet the following service levels:

- Escalation of requests to the appropriate contact within one business day
- Notification to the requestor of all escalations within one business day
- Provide call logs requested by the MCE within one business day
- Answer at least 90% of all calls within 30 seconds ("answered" means the call is picked up by a qualified staff person)
- Average hold time shall not exceed 30 seconds
- Resolve all prior authorization (PA) requests within 24 hours
- Resolve 95% of all call queries with the first call
- Notification to the MCE of call breaches or system downtimes within 1 hour

6.8.6 E-Prescribing

The MCE 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 MCE shall supply the EHR systems with information about member eligibility, patient history, and the applicable PDL or drug formulary.

6.9 Emergency Care

The MCEs must cover emergency services for all HIP members without the need for prior authorization or the existence of a contract with the emergency care provider. Services for treatment of an emergency medical condition, as defined in *42 CFR 438.114* and *IC 12-15-12* (subject to the *prudent layperson* standard), must be available 24 hours a day, 7 days a week.

The MCE must cover the medical screening examination, as defined by the *Emergency Medical Treatment and Active Labor Act* (EMTALA) regulations at *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 MCE must also comply with all applicable emergency services requirements specified in *IC 12-15-12*. The MCE must reimburse out-of-network providers at the standard HIP reimbursement rates established by the Secretary, unless other payment arrangements are made, as long as the provider is an IHCP provider (IHCP enrollment can be retroactively contracted to facilitate payment). HIP reimburses at the state-directed minimum fee schedule established by the state. Additional information can be found in the *Hospital Assessment Fee* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers.

The MCE is required to reimburse for the medical screening examination and facility fee for the screening. The MCE is not required to reimburse providers for services rendered in an emergency department (ED) for treatment of conditions that do not meet the prudent layperson standard as emergency medical conditions, unless the MCE authorized the treatment.

In accordance with *42 CFR 438.114*, the MCE may not determine what constitutes an emergency on the basis of lists of diagnoses or symptoms. The MCE 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 MCE instructs the member to seek emergency services per 42 CFR 438.114(c)(1)(ii)(A)-(B). The MCE may not deny or pay less than the allowed amount for the Current Procedural Terminology (CPT) code on the claim without offering the provider the opportunity for a medical record review. When the MCE 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 medicine, nursing, or social work.

The MCE is prohibited from refusing to cover emergency services if the ED provider, hospital, or fiscal agent does not notify the member's primary medical provider (PMP) or the MCE of the member's screening and treatment within 10 calendar days of presentation for emergency services. The member who has an emergency is not liable for the payment of subsequent screening and treatment required to diagnose or stabilize the specific condition. 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. The physician's determination is binding, and the MCE may not challenge the determination.

The MCE must comply with policies and procedures set forth in the *Emergency Services* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers regarding ED services.

Effective April 1, 2020, if the MCE 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 MCE must check at a minimum the diagnosis codes in fields 67 and 67A-E on the UB04 and 21A-F on the CMS 1500 against the emergency department autopay list.

By April 1, 2020, the MCE'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, then the MCE must reimburse for physician services billed on a *CMS-1500* claim form. The MCE must reimburse for facility charges billed on a *UB-04* claim form if a prudent layperson review determines the service was not an emergency.

The MCE must demonstrate to the state that it has the following mechanisms in place to facilitate payment for emergency services and manage ED utilization:

* A mechanism for a plan provider or MCE representative to respond within one hour to all ED providers 24 hours per day, seven days per week. The MCE is financially responsible for the post-stabilization services if the MCE fails to respond to a call from an ED provider within 1 hour.
* A mechanism to track the emergency services notification to the MCE (by the ED provider, hospital, fiscal agent, or member's PMP) of a member's presentation for emergency services.
* A mechanism to document that a member's PMP referred the member to the ED and to pay claims accordingly.

* A mechanism to document a HIP member's referral to the ED by the MCE's 24-hour nurse call line, and to waive ED copayments for HIP members accordingly. This requirement includes a mechanism to communicate the copayment waiver to the emergency services provider.

* A mechanism to document a HIP member's inappropriate emergency department utilization, and to communicate ED copayments for HIP members accordingly.

* A mechanism and policies and procedures for conducting prudent layperson reviews within 30 days of receiving medical records.

6.9.1 Post-Stabilization Care

As described in *42 CFR 438.114(e)* and *IC 12-15-12*, the MCE must cover post-stabilization services related to an emergency medical condition to maintain, improve, or resolve the member's condition. The MCE must demonstrate to the state that it has a mechanism in place to respond to ED providers' requests for authorization to continue post-stabilization care. MCEs must respond to these requests within one hour, 24 hours per day, 7 days per week.

6.9.2 Emergency Department Copayment Procedure

Except for HIP members otherwise exempt from cost-sharing, a copayment applies when a HIP member uses the ED for nonemergency services, as specifically described in *405 IAC 10-7-9*. Providers will collect the copayment from the member, and POWER Account funds cannot be used by the member to pay the nonemergency copayment. The MCE must include copayment information on the member's ID card. Provider payments are reduced by the applicable copayment amount.

All HIP members will incur an $8 copayment for all non-emergent ED visits. The copayment is waived if the member called the MCE nurse hotline before the ED visit.

HIP members who are exempt from cost-sharing (for example, members who are pregnant or members identified as American Indians/Alaska Natives (AIs/ANs), pursuant to *42 CFR 136.12*), will not be required to pay copayments for nonurgent use of hospital ED services.

The member must receive an appropriate medical screening examination under *Section 1867* of the *Emergency Medical Treatment and Active Labor Act*. Any applicable copayments must 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 24 hours of the original visit. In addition, the member copayment must be waived for any member who contacts the MCE's 24-hour nurse call line before utilizing the ED. The 24-hour nurse call line should advise members on their medical conditions and the appropriate setting to receive care. Regardless of the advice provided, a member who calls the 24-hour nurse call line before obtaining ED services for the same medical condition for which the member sought medical advice from the hotline will not be subject to an ED copayment. The MCE must have a process in place to communicate ED copayment waivers to hospital emergency providers on a prospective basis.

If an ED copayment was incorrectly collected, the MCE must refund that copayment back to the member.

Assuming that a member has an available and accessible alternate non-emergency services provider and the emergency provider has determined that the individual does not have an emergency medical condition; and that the member did not receive a waiver from the MCE's 24-hour nurse call line, the hospital must inform the member of the following before providing the non-emergency services:

* The hospital may require payment of the copayment before the service is provided
* The hospital can provide the name and location of an alternate nonemergency services provider that is available and accessible

* An alternate provider may be able to provide the services without a copayment
* The hospital can provide a referral to coordinate scheduling this treatment, and
* The member cannot use their POWER Account to pay emergency department copayments.

The MCE must instruct its provider network of the ED services copayment policy and procedure, such as the hospital's notification responsibilities (outlined previously) and the circumstances under which the hospital must waive or return the copayment.

6.10 Behavioral Health

Behavioral health services, with the exception of Medicaid Rehabilitation Option (MRO) and *1915(i)* services, are a covered benefit under the HIP program. The MCE is responsible for managing and reimbursing all such services in accordance with the requirements in this section. In furnishing behavioral health benefits, including any applicable utilization restrictions, the MCE shall comply with the *Mental Health Parity and Additions Equity Act* (MHPAEA). This includes, but is not limited to:

- 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.
- Ensuring compliance with MHPAEA for any benefits offered by the MCE 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 when made available for medical and surgical benefits.

The MCE must provide behavioral health services, which include mental health and substance abuse services, according to the requirements in this section. In doing so, the MCE must ensure 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 MCE must develop protocols to do the following:

- Provide care that addresses the needs of 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 MCE, and the behavioral healthcare provider.
- Coordinate management of utilization of behavioral health care services with MRO and 1915(i) services and services for physical health.

6.10.1 Substance Use Disorder and Serious Mental Illness

The §1115 Substance Use Disorder (SUD) and §1115 Serious Mental Illness (SMI) demonstration waivers enable federal financial participation (FFP) for short-term/acute inpatient stays (both SUD and SMI) and residential stays (SUD only) in a qualifying Institution for Mental Disease (IMD).

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. MCEs may, but are not required, to use an IMD in

lieu of other behavioral health services. The MCE is prohibited from requiring an enrollee to access behavioral health services at an IMD.

It is longstanding federal policy not to reimburse states for inpatient stays in facilities that qualify as IMDs regardless of facility designation. 42 CFR §435.1010 defines an IMD 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.*

The SUD and SMI demonstrations bypass the federal IMD exclusion by submitting to specific requirements for their respective qualifying acute inpatient stays by providing rigorous data analysis, evaluation, and submission to the Centers for Medicare and Medicaid Services (CMS); and by meeting specified goals and benchmarks over the approved waiver periods.

Under both waivers, the state is able to draw down federal matching funds for these types of inpatient stays and services in IMDs, which reduces financial burden on the state for being the sole source of funding. These waivers also expand the state's network of SUD/SMI providers and allow for more access across the continuum of care by providing individuals with more appropriate treatment options.

Eligible individuals must be age 21-64 and have a diagnosis of SUD or SMI as the reason for the stay. The SUD waiver demonstration allows for inpatient and residential stays while the SMI waiver demonstration only allows for inpatient.

Under the SMI waiver, IMDs must additionally be certified as a Private Mental Health Institution (PMHI) by the Division of Mental Health and Addiction (DMHA) in order to meet the criteria for a qualifying IMD. There is no corresponding certification requirement for IMD providers under the SUD waiver.

IMD providers must also maintain average length of stay (ALOS) requirements under SUD and SMI waivers. SUD stays are limited to up to 15 days in a calendar month. SMI stays can be up to 60 days, but all IMDs under the SMI waiver must be under a statewide ALOS of 30 days for all acute inpatient psych stays.

For SUD stays exceeding 15 days in a calendar month where the member is not awaiting placement in a state hospital, the member will remain enrolled in the Plan and the Plan will continue to provide care coordination services and reimburse all covered services. Additionally, for these stays, the state shall recover the entire monthly capitation payment for the member.

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

6.10.2 Behavioral Healthcare Services

The MCE must provide all medically necessary community-based, partial hospital, and inpatient hospital behavioral health services as identified in this section of this policy manual and MCE Contract Exhibit 3.

The MCE provides behavioral health services through hospitals, offices, clinics, in home, and other locations, as permitted under state and federal law. A full range of services, including crisis services, indicated by the behavioral healthcare needs of members, must be available to members.

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

The MCE must allow members to self-refer to any behavioral healthcare provider in the MCE's network without a referral from the PMP or without MCE authorization. Members may also self-refer to any IHCP-enrolled psychiatrist.

The MCE is contractually mandated that its behavioral healthcare network providers notify a member's MCE within five calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications, and so forth. Disclosure of mental health records by the provider to the MCE and to the PMP 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 MCE must develop 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, and so forth, are mechanisms to ensure care coordination and the reciprocal exchange of health information between physical and behavioral health providers. The MCE must require the behavioral health provider to share clinical information directly with the member's PMP.

6.10.3 Behavioral Health Provider Network

The state requires MCEs to develop a sufficient network of behavioral health providers to deliver the full range of behavioral health services. The network must include psychiatrists, psychologists, clinical social workers, and other licensed behavioral healthcare providers. In addition, MCEs must provide inpatient care for a full range of mental health and substance abuse diagnoses. All services covered under the clinic option must be delivered by licensed psychiatrists and health service provider in psychology (HSPP), or by an advanced practice nurse or person holding a master's degree in social work, marital and family therapy, or mental health counseling. MCEs are required to provide at minimum access to two psychiatrists within 60 miles of the member's residence.

For non-psychiatrist providers, the MCE is encouraged to contract with all Division of Mental Health and Addiction (DMHA)-certified community mental health centers (CMHCs). If all CMHCs are not included in the provider network, then the MCE must demonstrate that this does not prevent coordination of care with MRO and *1915(i)* State Plan services. Further, the MCE must, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs and must provide physical health and other medical information to the appropriate CMHC for every member.

The DMHA conducts regular annual Consumer Service Reviews to evaluate the quality of care provided in CMHCs. In addition to the regular oversight that the MCE provides for contracted CMHCs, the MCEs must use the results of DMHA's review to inform contracting decisions, to monitor contracted CMHCs, and to develop improvement plans with contracted CMHCs.

The MCE must train its providers to identify and treat members with behavioral health disorders and must train PMPs and specialists on when and how to refer members for behavioral health treatment. The MCE must also train providers to screen and treat individuals who have co-existing mental health and substance abuse disorders. The MCE is responsible for ensuring that its behavioral health network providers are trained in cultural diversity and can respectfully and effectively interact with individuals with varying racial, ethnic, and linguistic differences. The MCE must provide to the state its written training plan, including dates, methods (such as seminars, web conferences, and so forth), and subject matter for integration and cultural competency training.

Members must be able to receive timely access to medically necessary behavioral health services.

In urban areas, the MCE must provide at least one behavioral health provider within 30 minutes or 30 miles from the member's home. In rural areas, the MCE must provide at least one behavioral health provider within 45 minutes or 45 miles from the member's home. The availability of professionals will vary, but access problems may be especially acute in rural areas. The MCE must provide assertive outreach to members in rural areas where behavioral health services may be less available than in more urban areas.

The MCE also must monitor utilization in rural and urban areas to assure equality of service access and availability.

The following list represents behavioral health providers that should be available in the MCE's network:

- Outpatient mental health and addiction clinics
- Community mental health centers
- Licensed clinical addiction counselors;
- Licensed psychologists
- Health services providers in psychology (HSPPs)
- Certified social workers
- Licensed clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses under *IC 25-23-1-1(b)(3)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Marital and family therapist
- Licensed mental health counselors

The MCE must 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 60 miles. Exceptions must be justified and documented to the state on the basis of community standards for accessing care.

6.10.4 Case Management for Members Receiving Behavioral Health Services

The MCE must provide case management for members receiving behavioral health services, and for any member at risk for an inpatient psychiatric or substance abuse hospitalization. The MCE must ensure the coordination of physical and behavioral healthcare among all providers treating the member. At least quarterly, the MCE must send a behavioral health profile to the respective PMP. The behavioral health profile lists physical and behavioral treatment received by the member during the previous reporting period. Information about substance abuse treatment and HIV/AIDS should only be released if member consent has been obtained.

The MCE must 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 MCE must provide case management services for any member at risk for inpatient psychiatric or substance abuse hospitalization, and for members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than 90 calendar days following that inpatient hospitalization. Case managers must contact members during an inpatient behavioral health hospitalization, or immediately when they are notified of a member's inpatient behavioral health hospitalization. The case managers must schedule an outpatient follow-up appointment to occur no later than seven calendar days following discharge for the inpatient behavioral health hospitalization.

Case managers must use the results of health screenings and more detailed health assessments (including the medically frail health assessments) to identify members who need case management services. Case managers must also monitor members receiving behavioral health services who are new to the MCE's plan to ensure that the members are linked to appropriate behavioral health providers. The case manager must monitor whether members are receiving appropriate services and whether members are at risk of over- or

under-utilizing services. The state must provide access *Core*MMIS to allow the MCE to monitor MRO utilization, which is covered by Medicaid FFS.

Case managers must regularly and routinely consult with the member's physical and behavioral health providers to facilitate sharing of clinical information, and to develop and maintain a coordinated physical health and behavioral health treatment plan for the member. In addition, with the appropriate consent, case managers must notify PMPs and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. Case managers must provide this notification within five calendar days of the hospital admission or emergency treatment.

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

6.10.5 Behavioral Healthcare Coordination

The MCE must ensure the coordination of physical and behavioral healthcare among all providers treating the member. The MCE must coordinate services for individuals with multiple diagnoses of mental illness, substance abuse, and physical illness. The MCE must facilitate reciprocal exchange of health information between physical and behavioral providers treating the member.

The state requires that the MCE share members' 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 MCE must contractually mandate that its behavioral healthcare network providers notify the MCE within five calendar days of the member's visit and submit information about the treatment plan, the member's diagnosis, medications, and other pertinent information. Disclosure of mental health records by the provider to the MCE 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. MCEs must contractually require every provider contracted with the MCE, including behavioral health providers, to ask and encourage members to sign a consent for releasing substance abuse treatment information to the MCE and to the PMP or behavioral health provider, if applicable.

MCEs must, 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 MCE contractually requires behavioral health providers to document and share the following information for that member with the MCE and PMP:

* Written summary of the member's treatment session
* Primary and secondary diagnoses
* Findings from assessments
* Medication prescribed
* Psychotherapy prescribed
* Any other relevant information

MCEs must, at a minimum, establish referral agreements and liaisons with both contracted and noncontracted CMHCs, and must provide physical health medical information to the appropriate CMHC for every member.

The MCE must 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 MCE must require the behavioral health provider to share clinical information directly with the member's PMP. The MCE 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, contacts, behavioral health profile templates, and outcomes data must be made available to the state on request.

6.10.6 Behavioral Health Continuity of Care

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

The MCE must require, through provider contract provisions, that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and continuing treatment before discharge. This treatment must be provided within seven calendar days from the date of the member's discharge. If a member misses an outpatient follow-up or continuing treatment, then the MCE must ensure that a behavioral healthcare provider or the MCE's behavioral health case manager contacts that member within three business days of the missed appointment.

Additional information about RBMC members admitted to Psychiatric Residential Treatment Facilities (PRTFs) can be found in the *Mental Health and Addiction Services* provider reference module on the Provider Reference Materials page at in.gov/medicaid/providers.

6.10.7 Partial Hospitalization Services for Behavioral Health

The state supports the implementation of partial hospitalization programs to provide a range of care to prevent hospitalization or act as a step-down service to transition members from inpatient hospitalization to community care. These programs must be highly intensive, time-limited medical services that provide a transition from inpatient psychiatric hospitalization to community-based care or serve as a substitute for inpatient admission. Partial hospitalization programs are highly individualized, with treatment goals that are measurable and medically necessary. Treatment goals must include specific time frames for achievement of goals and must be directly related to the reason for admission. To receive partial hospitalization services, members must have a diagnosed or suspected behavioral health condition and one of the following:

* Short-term deficit of the individual's daily functioning
* Serious deterioration of the individual's general medical or behavioral health is highly probable without structured intervention

The full service description and program requirements for coverage of partial hospitalization are located in the Indiana Administrative Code *405 IAC 5-20-8*. Additional information can be found in the *Mental Health and Addiction Services* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers.

6.11 Disease Management

The MCE must offer HIP members disease management services, at minimum, for the following:

- Sickle Cell Disease
- Asthma
- Depression
- Pregnancy
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism/Pervasive Developmental Disorder (PDD)
- Coronary Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Chronic Kidney Disease (CKD)
- Congestive Heart Failure (CHF)
- Diabetes
- Hypertension
- SUD

Members with excessive utilization or under-utilization for conditions other than those listed must also be eligible for the disease management services described in this section. Members with these conditions must be identified through the health screening tool referenced in Member Services and by identification of conditions based on claims.

The MCE must make a spectrum of disease management tools available to the population, including population-based interventions and case and care management. All case and care management disease management programs must identify members' psychosocial issues that may contribute to poor health outcomes and provide appropriate support services for addressing such issues.

The MCE must submit quarterly reports to the state on disease management programs, as outlined in the *MCE Reporting Manual*. The quarterly reports must include participation rates and utilization and cost statistics of both total members enrolled in the disease management programs, as well as HIP medically frail members enrolled in the disease management programs. For example, the diabetes disease management quarterly report will include:

- All medically frail members with two or more claims in the calendar year for diabetes, and the numerator shall include all members with two or more claims in the calendar year for diabetes, and
- All members with two or more claims in the calendar year for diabetes, and the numerator shall include those members enrolled in case or care management as defined in the following.

Separate, mutually exclusive calculations for members in case and care management shall be conducted. The reports must also identify any member at least three standard deviations outside of the mean of utilization of inpatient days, emergency department visits, and home health service days for the population group.

All disease management programs must encourage compliance with national care guidelines (such as American Diabetic Association) and offer incentives for a member's healthy behaviors. All members must be sent population-based disease management materials (such as educational fliers, screening reminders, and so forth). The state believes that the MCE's disease management programs serves as a critical area for pursuing continuous innovation in improving member health status, and disease management programs may be subject to on-site visits or external quality reviews.

The state reserves the right to require the MCE to have disease management programs for additional conditions in the future. The state provides three months' advance notice to the MCE if the state decides to add new diseases to the requirements of the disease management program.

The MCE is encouraged to offer additional disease management programs beyond those required in the Scope of Work. If the MCE provides additional disease management programs, then the MCE must also provide annual updates to the state documenting the strategies, outcomes, and efficacy of the additional disease management programs.

The state reserves the right to examine the MCE's disease management programs at any time, including during the proposal review process, before contract execution, during the readiness review, and during the term of the contract. The MCE must obtain the state's approval of materials related to disease management programs that is distributed to members or providers.

6.11.1 Disease Management Member Interactions

Disease management consists of three levels of MCE-member interaction:

- Population-based interventions
- Care management
- Complex Case management

6.11.2 Population-Based Interventions

The MCE must engage members with the conditions of interest through disease-specific and population-based preventive care interventions, including educational materials and appointment and preventive care reminders. All pregnant members must receive standard pregnancy care educational materials, the state-approved tobacco cessation materials, and access information for 24-hour nurse call line. Members may be eligible for more than one condition. Materials must be delivered through postal and electronic direct-to-consumer contacts, as well as web-based education materials, including clinical practice guidelines. Materials must also be at a fifth-grade reading level. All members with conditions of interest must receive materials no less than bi-annually. The MCE must document the number of members with conditions of interest, mailings and website hits.

6.11.3 Care Management

The MCE's protocol for referring members to care management must be reviewed by the state and must be based on identification through the health screening, or when the claims history suggests need for intervention. In addition to population-based disease management educational materials and reminders, these members must receive more intensive services. Members with newly diagnosed conditions, increasing health services or emergency services utilization, evidence of pharmacy noncompliance for chronic conditions, or identification of special healthcare needs, must be strongly considered for care management. Care management services include direct consumer contacts to assist members with the following:

- Scheduling appointments
- Locating specialists and specialty services
- Transportation needs
- 24-hour nurse call line
- General preventive services, such as mammography
- Disease-specific reminders, such as Hgb A1C

- Pharmacy refill reminders
- Tobacco cessation
- Education about using primary care and emergency services

The MCE must make every effort to contact members in care management via telephone. Materials must also be delivered through postal and electronic direct-to-consumer contacts, as well as web-based education materials, including clinical practice guidelines. Materials must be developed at the fifth-grade reading level. All members with conditions of interest must receive materials no less than quarterly. The MCE must document the number of persons with conditions of interest, outbound telephone calls, telephone contacts, category of intervention, intervention delivered, mailings, and website hits. Care management must be coordinated with the Right Choices Program for members qualifying for the Right Choices Program. However, the Right Choices Program is not a replacement for care management.

6.11.4 Complex Case Management

The MCE's protocol for referring members to complex case management must be reviewed by the state and must be based on identification through the health screening as having special care needs, a condition of interest named previously, or a chronic or comorbid disease history that indicates the need for real-time, pro-active intervention. Persons with clinical medical training must be required to develop the member's care plan, and care plans must be reviewed by the medical director. Care plans developed by the MCE must include clearly stated healthcare goals, defined milestones to document progress, clearly defined accountability and responsibility, and timely, thorough review with appropriate corrections (course changes), as indicated.

The MCE's case management services must involve the active management of the member and their group of healthcare providers, including physicians, medical equipment, transportation, and pharmacy. The member's healthcare providers must be included in the development and execution of member care plans. Care plans and case management must take into account comorbidities being jointly managed and executed. Separate care plans for each medical problem for the same member may fragment care and add to the potential of missing interactive factors.

The MCE must contact members via telephone and in person, as indicated by their need. Case managers must engage in care conferences with the member's healthcare providers, as necessary. Members must receive the same educational materials, delivered in the same manner as to those persons receiving care management.

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.

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 MCE must engage the member in learning about the member's health condition and follow the case management plan developed.

RCP Care Plans

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

6.12 24-Hour Nurse Call Line

The MCE must provide nurse triage telephone services for members to receive medical advice 24 hours a day, seven days a week from trained medical professionals. The 24-hour nurse call line must be well-publicized and designed to help discourage members' inappropriate use of the emergency department, particularly for members in disease management. The 24-hour nurse call line must have a system in place to communicate all issues with the member's PMP. In addition, the 24-hour nurse call line must be equipped to provide advice and copayment waivers for HIP member's seeking services from hospital emergency departments. See *Emergency Department Copayment Procedure* for more information on the state's emergency department copayment application for HIP members and available copayment waivers.

6.13 Services Carved Out of Risk-Based Managed Care Capitation

The following are other services that are carved out of capitation payments to the MCEs:

* Medicaid Rehabilitation Option (MRO) services rendered by provider specialty 111 – Community Mental Health Center – to individuals, families, or groups living in the community who need intermittent aid for emotional disturbances or mental illness. MRO services include outpatient mental health services, partial hospitalization, case management, and assertive community treatment (ACT) intensive case management. MCEs are also responsible for care coordination for members receiving MRO services. Additional information can be found in the *Medicaid Rehabilitation Option (MRO) Services* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers
* 1915(i) State Plan Home and Community-Based Services. The state has three 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 MCEs' financial responsibility. A listing of carved-out 1915(i) services is provided in the *Medicaid Rehabilitation Option (MRO) Services* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers

The following benefits and services are noncovered under HIP:

- Services that are not medically necessary
- Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly
- Except for *HIP Maternity*, *HIP State Plan*, and *HIP Plus*, chiropractic services, except for services covered under the plan that are within the scope of practice of a chiropractor (for example, physical therapy) - Update 6-2011 *IAC 9*
- Long-term or custodial care
- 1915(c) Home and Community-Based Services (HCBS) Waiver
- Psychiatric Treatment in a State Hospital

- Behavioral and Primary Healthcare Coordination (BPHC) Services
- Experimental and investigative services, as determined by the state
- Day care and foster care
- Personal comfort or convenience items
- Cosmetic services, procedures, equipment or supplies, and complications directly relating to cosmetic services, treatment or surgery, with the exception of reconstructive services performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or a previous medically necessary procedure
- Hearing aids and associated services, except for individuals 19 or 20 years of age - update 6-2011 *IAC 9.*
- Safety glasses, athletic glasses and sunglasses
- LASIK and any surgical eye procedures to correct refractive errors
- Vitamins, supplements, and over-the-counter medications, with the exception of insulin
- Wellness benefits, other than tobacco use cessation
- Diagnostic testing or treatment in relation to infertility
- In vitro fertilization
- Gamete or zygote intrafallopian transfers
- Artificial insemination
- Reversal of voluntary sterilization
- Transsexual surgery
- Treatment of sexual dysfunction
- Body piercing
- Alternative or complementary medicine including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, massage therapy and herbal, vitamin, or dietary products or therapies
- Treatment of hyperhidrosis
- Court-ordered testing or care, unless medically necessary
- Travel-related expenses including mileage, lodging, and meal costs
- Missed or canceled appointments for which there is a charge
- Services and supplies provided by, prescribed by, or ordered by immediate family members, such as spouses, caretaker relatives, siblings, in-laws, or self
- Services and supplies for which an enrollee would have no legal obligation to pay in the absence of coverage under the plan
- Evaluation or treatment of learning disabilities (except for individuals 19 or 20 years of age eligible for EPSDT services)
- Routine foot care, with the exception of diabetes foot care
- Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot, and tarsalgia
- Any injury, condition, disease, or ailment arising out of the course of employment, if benefits are available under any Worker’s Compensation Act or other similar law
- Examinations for the purpose of research screening
- Elective abortions and abortifacients

- Abortions are covered only if the pregnancy is the result of an act of rape or incest, or if 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, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. No other abortions are covered.

6.14 Healthy Indiana Plan Pregnancy

HIP provides coverage for pregnancy-related services. If a woman becomes pregnant while enrolled in HIP and has income at or below 138% of the FLP, she will receive *HIP Maternity* benefits under the Medicaid aid category MAMA beginning the first of the month following notification of pregnancy. She will continue under *HIP Maternity* until her postpartum coverage period is over. Members will not change programs or MCEs during their pregnancy or at their redetermination, as long as they continue to meet eligibility requirements.

Pregnant applicants with income at or below 138% of the FPL and who are eligible for the HIP program will be enrolled in *HIP Maternity*. These applicants may be determined eligible for retroactive coverage for up to three months prior to their application date. If eligible for retroactive coverage, they will receive Package A Standard Plan (RM – Retro Maternity) under the fee-for-service delivery system as the member's coverage during the retroactive time period, with no enrolling MCE until the first of the following month in which eligibility was determined.

In addition to member self-reporting, the MCE shall also develop policies and procedures for quickly identifying pregnant HIP members. The MCE shall notify the state's fiscal agent within one business day of confirming a member's pregnancy. The notice must include the pregnancy start date as well as the expected delivery date. The date of confirmation is the date the MCE receives notification of member pregnancy from the provider. If the MCE discovers member pregnancy before provider confirmation, such as through claims data, then the MCE shall confirm member pregnancy with the provider within three business days of discovery.

The MCE is responsible for informing the member about *HIP Maternity*, and this information must, at minimum, be included in the MCE's member handbook. The MCE shall also work closely with its providers to complete the Notification of Pregnancy risk assessment on all pregnant members.

HIP Maternity has additional benefits (same as *HIP State Plan*), such as non-emergency transportation. Pregnant members shall not be subject to any cost-sharing. After pregnancy has been confirmed, the MCE must 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 of notification. This may occur before the member has been moved into the MAMA aid category. Pregnancy notifications received by the state less than six business days before the end of the month are 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 MCE shall have policies and procedures in place for quickly identifying pregnant members and suspending all cost-sharing.

As of April 1, 2022, HIP Maternity benefits will continue for a twelve (12) month postpartum period which begins on the first day of the month following the end of the pregnancy. The MCE will provide pregnancy, postpartum, and HIP benefits aligned with the dates and benefits specified on the 834. The MCE shall communicate regularly with the member during the postpartum period. Additional guidelines regarding the MCE's responsibility to assist pregnant members to obtain and maintain coverage are located in this Manual.

The submission of the supplemental file indicating that a member delivery has occurred generates a maternity delivery capitation payment for HIP members.

Pregnant women who transfer to *HIP Maternity* can re-enroll in HIP after their pregnancy ends if they still meet HIP eligibility requirements. Instead of having to reapply after the pregnancy coverage ends, the member would become *HIP Basic Potential Plus* and would have 60 days to make her payment.

If a woman moves from HIP to *HIP Maternity* and/or re-enrolls in *HIP Basic*+ after her pregnancy and postpartum coverage period, the assigned MCE must provide for continuity of care and the coordination of medically necessary healthcare services during the transition period. If the member is transitioning from a different plan, the HIP MCE must honor the prior MCE's care authorizations for a minimum of 90 calendar days.

6.14.1 Pregnant Member Education

MCEs must establish policies and procedures to identify pregnant members and explain the benefits of *HIP Maternity* coverage. The MCE's procedures must include a description of the process they use to follow up with pregnant members and make sure the member successfully obtains pregnancy coverage (See *405 IAC 98-5.*)

The MCE's policies and procedures must specify that after the MCE becomes aware of a member's pregnancy, the MCE informs the member of her options during pregnancy to receive pregnancy-related services. These policies and procedures must specify or provide the following:

- Submit monthly reports to the state about members who become pregnant. This monthly report is called the Pregnancy Identification report, and it is due 30 days after the end of each month. These reports must include members' ID numbers.
- Establish provider education programs that inform providers about the HIP pregnancy policy.

In addition, the MCE must inform members, in writing, that the member must promptly report the end of pregnancy. *HIP Maternity* members will be opened into *HIP Basic with Potential Plus* at the end of their postpartum coverage period.

6.15 Continuity of Care

The state is committed to providing continuity of medical care during a member's transition period among the various IHCP programs. The MCE is financially responsible for providing medically necessary care during the transition from one MCE to another Medicaid aid category/program. The MCE must have mechanisms in place to ensure the continuity of care and coordination of medically necessary healthcare services for its members. Some examples of the need for special consideration for continuity of care include, but are not limited to, the following:

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

Newly enrolled members in the third trimester of their pregnancy may continue to receive prenatal, delivery, and postpartum care from their previous physicians. When the member notifies the MCE that she wishes to maintain the existing relationship for the duration of the pregnancy, the MCE contacts the doctor to confirm the existing relationship and arrange for payment of services to the out-of-network provider.

In situations such as a member or PMP disenrollment, the MCE must facilitate care coordination with other MCEs or other PMPs. When receiving members from another MCE or the fee-for-service system, the MCE must honor the previous care authorizations for a minimum of 90 calendar days from the date of enrollment with the MCE. The MCE must 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 begins on the date the MCE receives the member's fully eligible file from the state.

When members enroll with an MCE or when they change MCEs, they may have received authorizations for services or procedures that were not completed on the effective dates of their enrollment in their new health plan. The prior authorizations may be for specific procedures, such as surgery, or for ongoing procedures authorized for specified durations, such as physical therapy or home healthcare. Requiring duplicate authorizations from the new health plan places an additional burden on the provider and can delay or inappropriately deny member's treatments or services. MCEs must honor outstanding prior authorizations given for services within the IHCP (whether through managed care or traditional FFS) for the first 90days of a member's effective date in the new health plan. This authorization extends to any service or procedure previously authorized, including, but not limited to, surgeries, therapies, pharmacy, home healthcare, and physician services. MCEs may be required to reimburse out-of-network providers during the 30-day transition period.

When a member transitions to another source of coverage, the MCE 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.

The MCE is responsible for ensuring continuity of care coordination whenever a member disenrollment from the MCE occurs during an inpatient stay.

In instances where reimbursement for the stay is based on a diagnosis-related group (DRG) methodology, the admitting MCE is responsible for the entire inpatient stay through member discharge. The admitting MCE is 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. If the member is transitioning from the admitting MCE to another MCE or from the admitting MCE to Traditional Medicaid, the admitting MCE is responsible for care coordination, including coordination of discharge plans, with the receiving MCE or with the inpatient provider, as applicable.

In instances where reimbursement for the inpatient stay is based on a level-of-care (LOC) methodology, the admitting MCE is responsible for the days of the inpatient stay during which the member is enrolled with the MCE and for the transition of care coordination for the remainder of the stay. The admitting MCE is financially responsible for the *per diem* payments and any outlier payments (without capitation payment) associated with the days the member remains enrolled with the admitting MCE. If the member is transitioning from the admitting MCE to another MCE or from the admitting MCE to Traditional Medicaid, the receiving MCE or the Traditional Medicaid program is responsible for the *per diem* payments associated with the days the member is enrolled with the receiving MCE or in Traditional Medicaid, until the member is discharged from the hospital or the member's eligibility for Medicaid terminates. The admitting MCE is responsible for the transition of care coordination with the receiving MCE or with the inpatient provider, as applicable.

The entity that issued the original prior authorization provides the new health plan with the following:

- Member identification number (MID)
- Provider ID number

- Procedure codes
- Duration and frequency of authorized services
- Other information pertinent to the determination

This information can be provided in spreadsheet format, computer screen prints, authorization form copies, or any other mutually agreed-upon format.

6.16 Provision of Enhanced Services in Risk-Based Managed Care

In addition to mandated covered benefits and services, MCEs are encouraged to offer enhanced services to their members. In particular, MCEs are encouraged to offer enhanced services that address prevention, personal responsibility, and cost and quality transparency.

For enhanced services developed for HIP, the enhancements must be developed to align with the overall program goals aimed at creating a commercial market experience and encouraging member participation in HIP. POWER Account funds for HIP members may be used to pay for enhanced services obtained before the member's $2,500 deductible has been met.

The MCE may not offer gifts or incentives greater than $200 per incentive and not to exceed $300 per member per year. Priority incentive programs that offer greater gifts or incentives must be approved by the state. The MCE may petition the state for authorization to offer items or incentives with a higher value if the items are intended to promote the delivery of certain preventive care services. Member incentive programs may not be advertised to non-members. The state does not approve any mass marketing materials that describe member incentive programs. MCEs must advertise incentives only to current members through media such as member handbooks, letters, or telephone calls directed to current membership.

MCEs must submit proposals in writing to the State 60 calendar days before implementing the enhanced service. All enhanced services must comply with marketing, education, and outreach guidelines.

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

- Enhanced transportation arrangements (for example, nonemergent transportation for HIP Plus or HIP Basic members, transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.)
- Enhanced tobacco dependence services
- Additional disease management programs or incentives
- Healthy lifestyles incentives
- Group visits with nurse educators and other patients

6.17 Out-of-Network Services

With the exception of certain self-referral service providers and emergency medical care and the requirements to allow continuity of care for pregnant women transferring to the MCE in their third trimester, the MCE may limit its coverage to services provided by in-network providers, after the MCE has met the network access standards set forth in *Provider Education and Outreach*. However, in accordance with *42 CFR 438.206(b)(4)*, the MCE must authorize and pay for out-of-network care if the MCE's provider network is unable to provide necessary covered medical services within 30 miles of the member's residence for primary care and within 60 miles of the member's residence for specialty care. The MCE must authorize these out-of-network services within the time frame established in *Authorization of Services and Notices of Action*. The MCE must adequately cover the services for as long as the MCE is unable to

provide the covered services in network. The MCE must require out-of-network providers to coordinate with the MCE for payment and ensure that the cost to the member is no greater than it would be if the services were furnished in network.

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

MCEs must make nurse practitioner or physician extender services available to members and must inform members that these services are available. MCEs must allow members to use the services of out-of-network nurse practitioners if nurse practitioners are not available within the MCE's network in the member's service area.

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

The MCE may not require an out-of-network provider to acquire an MCE-assigned provider number for reimbursement. A National Provider Identifier (NPI) is sufficient for out-of-network provider reimbursement.

6.17.1 Out-of-Network Provider Reimbursement

The MCE must reimburse any out-of-network provider's claim for authorized services provided to HIP members at the standard HIP reimbursement rates established by the Secretary. The HIP reimbursement rates are based on the state-directed minimum fee schedule established by the state.

6.18 Opioid Treatment Program (OTP)

The MCE must provide coverage for the daily Opioid Treatment Program (OTP). A daily opioid treatment program includes:

- Administration and coverage of methadone
- Routine drug testing
- Group therapy
- Individual therapy
- Pharmacological management
- HIV testing
- Hepatitis A, B, and C testing
- Pregnancy tests
- Tuberculosis testing
- Syphilis testing
- Follow-up examinations
- Case management
- One (1) 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 OMPP 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 includes:

- 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).

All marketing efforts must be targeted to the general community in the managed care entity's (MCE's) entire service area. In accordance with *42 CFR 438.104*, the MCE cannot conduct, directly or indirectly, door-to-door, telephone, or other *cold-call* marketing enrollment practices. Cold-call marketing is defined in *42 CFR 438.104* as *any unsolicited personal contact by the MCE with a potential Medicaid enrollee*. Additionally, the MCE must not distribute any marketing materials without first obtaining the state approval, and such approval must be received at least thirty (30) calendar days prior to distribution.

7.1 Marketing and Outreach

The MCE may market by mail, mass media advertising (for example, radio, television, and billboards), and community-oriented marketing directed at potential members. Community oriented marketing such as participation in community health fairs is encouraged. The MCE must conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the state. The MCE must provide information to potentially eligible individuals who live in medically underserved rural areas of the state. Marketing materials must include the requirements and benefits of the MCE's health plans and provider network.

The MCE cannot, under any circumstances, encourage a potential member to join its health plan by offering any other type of insurance as a bonus for enrollment. The MCE must make every effort to ensure that all potential members make their own decision as to whether or not to enroll. Marketing materials and plans must be designed to reach a distribution of potential members across age and sex categories. Potential members must not be discriminated against based on their health status or their need for healthcare services, or any other basis inconsistent with state or federal law.

The MCE may offer potential members tokens or gifts of nominal value, so long as the MCE acts in compliance with all marketing provisions provided for in *42 CFR 438.104*, and other federal and state regulations and guidance regarding incentives for the Medicare and Medicaid programs.

Any outreach and marketing activities (written and verbal) must be presented and conducted in an easily understood manner and format, at a fifth-grade reading level, and must not be misleading or designed to confuse or defraud. Examples of false or misleading statements include, but are not limited to, the following:

- Any assertion or statement that the member or potential member must enroll in the MCE's health plan to obtain benefits or to avoid losing benefits
- Any assertion or statement that the MCE is endorsed by the Centers for Medicare & Medicaid Services (CMS), the federal or state government, or a similar entity
- Any assertion or statement that the MCE's health plan is the only way to obtain benefits under the Healthy Indiana Plan (HIP) program

The MCE may distribute or mail an informational brochure or flyer to potential members or provide (at its own cost, including any costs related to mailing) such brochures or flyers to the state for distribution to individuals that apply for the HIP program throughout the state.

The MCE may submit promotional poster-sized wall graphics to the state for approval. If approved, then the MCE may make these posters available to the local Division of Family Resources (DFR) offices and other enrollment centers for display in an area where application and MCE selection occurs. The local DFR offices and enrollment centers may display these promotional materials at their discretion. The MCE may display these same promotional materials at community health fairs or other outreach locations. The state

must pre-approve all promotional and informational brochures or flyers, and all graphics, before they are displayed or distributed.

7.2 Member Enrollment

Applicants for the HIP program have an opportunity to select an MCE on their application. MCEs are expected to conduct marketing and outreach efforts to raise awareness of the programs and their product. The enrollment broker (EB) is available to help members choose an MCE. Applicants who do not select an MCE on their application are assigned to an MCE according to the state's auto-assignment methodology.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).

Individuals enrolled in HIP may change MCEs without cause:

- At any time before making the member's initial POWER Account contribution or within 60 days of being assigned to the MCE, whichever comes first or
- During MCE selection period for change effective the following benefit period.

HIP members do not have traditional Medicaid retroactive coverage. However, because HIP members must make an initial contribution before becoming fully eligible with the program effective the first day of the month in which the payment was made, there will typically be a small window of retroactive eligibility in the HIP plan for the period of time between when the payment was made (or in the case of *HIP Basic*, when the non-payment determination was made) and the effective date back to the first of that month. For example, if an MCE receives a HIP payment in the middle of the month, the MCE submits the payment record and requests an effective date back to the first of the month in which the payment was made. Pregnant applicants enrolling in HIP may be determined eligible for retroactive coverage for up to three months prior to their application date. If the applicant is eligible for retroactive coverage, the IHCP EVS will indicate Package A – Standard Plan as the member's coverage during the retroactive time period, with no enrolling MCE indicated. Retroactive coverage is paid through the FFS delivery system.

The Division of Family Resources (DFR) is responsible for determining Indiana Health Coverage Programs (IHCP) eligibility, including for the Healthy Indiana Plan (HIP). The DFR is also responsible for updating member eligibility and personal data, such as changes in household, including births, deaths, and so forth, for continuing enrollees at periodic eligibility redetermination dates. This data is entered into the Indiana Eligibility Determination Services System (IEDSS).

The fiscal agent for the state receives IEDSS enrollee eligibility files daily to update Core Medicaid Management Information System *(Core*MMIS). Enrollee data stored in *Core*MMIS is used to confirm eligibility for various IHCP programs, including HIP, during claims and capitation processing. Providers check enrollee eligibility through *Core*MMIS via the Eligibility Verification System (EVS).

The enrollment broker assists HIP members with managed care entity (MCE) selection if the enrollee does not select an MCE during the application process. The state retains sole responsibility for maintaining general IHCP member eligibility and aid categories. The state is also responsible for maintaining and updating member demographics. The fiscal agent cannot change member demographics. MCEs may contact the DFR if they have different information about the member than what is found in *Core*MMIS.

7.2.1 Healthy Indiana Plan and Aid Categories

HIP eligibility requirements are as follows:

- Person between the ages of 19 and 64
- If over 64, but considered a Low Income Parent/Caretaker that is not receiving Medicare, then may continue to be enrolled in HIP

- U.S. citizen
- Lawful permanent residents (LPRs) have to be in the U.S. for at least 5 years
- Indiana resident
- Household income at or below 133% with a 5% disregard of the Federal Poverty Level (FPL) for enrollment in *HIP Plus*
- Household income at or below 100% FPL for enrollment in *HIP Basic*

Enrollees are conditionally eligible until they have made their first Personal Wellness and Responsibility (POWER) Account contribution or $10 pre-POWER Account Contribution (PPAC). Some enrollees are opened into *HIP Basic* with a *Potential Plus* segment to allow for transitions from other coverage and recent incarceration. MCEs send payment records to the fiscal agent, which then sends the record to IEDSS, finalizing the member's enrollment in HIP. If an enrollee has household income at or below 100% FPL and does not make their first POWER Account contribution, the enrollee is enrolled in *HIP Basic*. If a conditionally eligible individual has income above 100% FPL, the individual is determined ineligible for HIP and must reapply. The same payment requirements apply to those in *HIP Basic* with a *Potential Plus* segment. Those members with income greater than 100% FPL must make a payment within 60 days or they will lose coverage.

The file layout for the Conditional Pay/No-Pay file can be found in the File Layouts section of the *MCE Secure Landing* page at in.gov/medicaid/partners. The username is *MCEhealthplans*. This site is password protected. MCEs can obtain the password by contacting their OMPP Contract Manager. The conditional pay/no-pay process runs daily Monday through Friday. A DSIB Prod email notice is generated to the MCE if an error is detected. The error type is included. If the file is not corrected and reposted within 30 minutes, the system carries on without processing the daily file. The MCE can then correct the records and add them to the next day's file.

Eligibility typically takes effect the first day of the month in which IEDSS registers contribution payment. Eligible HIP members are effective the first day of the month, and have term dates that are the last day of a month. The exception is if a member dies; then, the end date is the date of death.

7.2.2 Identification Cards

The MCE issues identification cards to its HIP members when they enroll in the program. The identification card must identify the member and provide current benefit information to their providers. New members are assigned a member identification number (MIDs) by the State when their information is first entered in IEDSS. MIDs, unique to each member, are randomly generated and assigned for life. The state will provide the MCE with each new member's MID for inclusion on the member identification card. The MCE must produce and mail the identification card to the new member within five business days after receiving enrollment confirmation from the state's fiscal agent.

Identification cards are not reissued for members who become eligible again after a period of ineligibility, unless cards are lost or stolen. If a card is lost or stolen, the member must contact their plan to request another ID card.

The HIP member ID card must contain the following information:

- HIP logo
- Member name
- Member ID
- Applicable emergency department (ED) copayment, or at minimum, include that ED copayments may apply and direct the provider to call the MCE for specific amounts

- Applicable copayments, or at minimum, include that copayments may apply and direct the provider to call the MCE for specific amounts
- Telephone numbers are printed on the card for the following:
    - Managed care entities member services
    - Emergency 911
    - NURSE on-call
    - Member services for Pharmacy
    - Pharmacy Prior Authorization and POS Helpline

MCEs must distribute their own health plan ID cards, with the state approval, to their enrolled members. However, MCEs may not require HIP members to produce the MCE health plan card to receive services.

MCEs must distribute an enrollment packet to each new member within five calendar days of receipt of member enrollment information via the eligibility files provided by FSSA. The Enrollment Packet must include the MID card, a welcome letter, an explanation of where to find information about the MCE's provider network information and a member handbook.

Providers are responsible for verifying eligibility before rendering services. A plan identification card does not guarantee current eligibility; providers must verify eligibility using the Eligibility Verification Service before rendering services. The member information is also sent on the 834s received daily by the plans.

Generally, providers and MCEs can verify eligibility by using the MID supplied by the member. If there are two MIDs, they are normally linked and either MID provides the eligibility information required along with the active MID. Occasionally, IEDSS or an MCE identifies members who have been issued more than one MID in error, and the MIDs have not been linked. In these cases, the MCE personnel who identify a member with a multiple active MIDs that are not linked must contact the fiscal agent with the information.

7.2.3 Member Enrollment Rosters

The state requires the MCE to accept as enrolled all individuals appearing on the enrollment rosters and be financially responsible for all members for whom the MCE receive a capitation payment. Additional capitation information is located in *Section 11: Information Systems*.

On behalf of the state, the fiscal agent notifies each MCE of all members enrolled in its HIP program. Using information obtained from IEDSS transmissions and from MCE assignments entered in *Core*MMIS by self-selection and auto-assignment, the fiscal agent generates daily *Health Insurance Portability and Accountability Act* (HIPAA) 834 MCE benefit enrollment and maintenance transactions, also known as enrollment rosters. The processes that create data begin each evening Monday through Friday. The rosters are typically generated the early morning hours of Tuesday through Saturday. Exceptions are state holidays. Because IEDSS files do not run on holidays, rosters are not generated. The following holidays affect IEDSS processing if they occur on business days:

- New Year's Eve
- New Year's Day
- Martin Luther King, Jr. Day
- Good Friday
- Primary Election Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day

- Election Day
- Veteran's Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

See the *834 MCE Benefit Enrollment and Maintenance Transaction* companion guide for file layout and data usage.

MCE member enrollment rosters provide MCEs with detailed lists of members for whom the MCE is responsible. Change files indicate new, terminated, or deleted members, or changes to continuing member records that have occurred since the previous change file was created. Audit files, created once a month, list all members effective with the MCE and region as of the date the audit file was created. HIP audit files run dates are the 1st and 15th of each month.

The segments of the member enrollment rosters are categorized in the *834 MCE Benefit Enrollment and Maintenance Transaction* companion guide change files as follows:

- Continuing enrollees
- New enrollees
- Terminated enrollees
- Deleted enrollees who appeared as eligible members on the previous roster, but whose eligibility terminated before the actual effective date with the MCE

Summary reports are also generated and posted to File Exchange for each of the MCE and region files. There are occasions when an MCE or region may not have any data to report for a given cycle. A systematic email is sent to the affected MCE's distribution list, indicating that there was no data to be reported, and therefore, no file to be produced. This applies mostly to change files.

7.2.4 Member Disenrollment

HIP members can be disenrolled from the HIP program. Members may be disenrolled if they:

- Were enrolled in error or because of a data-entry error.
- Lose eligibility in the IHCP.
- Move out of state.
- Become eligible in another Medicaid aid category.
- Pass away.
- Voluntarily withdraw from the program.

Examples of reasons for member disenrollment from the HIP managed care program to participate in another IHCP program include but are not limited to the following:

- The member is determined ineligible for managed care under the terms of the State Plan.
- A change in aid category causes the enrolled member to become ineligible for managed care.
- The member is admitted to a Psychiatric Residential Treatment Facility (PRTF). At admission, a level of care is assigned in *Core*MMIS, and the member is transitioned to fee-for-service.
- A residency change causes the enrolled member to become ineligible for managed care.

- The enrolled member meets long-term care (LTC) criteria, determined by Indiana Pre-Admission Screening (IPAS) and the Federal Pre-Admission Screening Resident Review (PASRR). HIP members requiring long-term care in a nursing facility or Intermediate Care Facilities for Persons with Intellectual Disability (ICF/ID) must be disenrolled from the HIP program and converted to fee-for-service eligibility in the IHCP. Before the nursing facility can be reimbursed by the IHCP for the care provided, the nursing facility must request a PASRR for nursing facility placement. The state must approve the PASRR request, designate the appropriate level of care in *Core*MMIS, and disenroll the member from HIP. The DFR must disenroll the member; there is no fee-for-service for HIP members. The MCE must coordinate care for its members who 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 *Long-Term Care* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers. The MCE is responsible for payment for up to 60 calendar days for its members placed in a long-term care facility while the level of care determination is pending. MCEs must monitor the care of members who are potential candidates for LTC so MCEs can help facilitate disenrollment from managed care.
- HIP members receiving psychiatric treatment in a state hospital shall not be disenrolled from HIP but should be directed to an alternative inpatient facility.
- An enrolled member who becomes eligible for Medicare is no longer eligible to participate in the HIP program. A member is disenrolled only after the Medicare indicator is received. It can take up to one week for a member to be disenrolled after the Medicare indicator is received. For HIP members, they go through the normal notification process and may remain in HIP while notification timelines continue and/or any appeal is filed with DFR. MCEs aware of a member with Medicare should treat HIP as secondary insurance coverage.
- An enrolled member who is designated *in a non-qualified immigrant status i*s limited to emergency services under IHCP Package E. They should not be enrolled in managed care.
- Other enrolled members as determined by the state.

The following disenrollment causes also apply to HIP members:

- The member, who is not determined medically frail, fails to make their POWER Account contribution timely, and has household income greater than 100% FPL.
- The member fails to submit timely their redetermination paperwork.
- The member fails to verify changes that impact their eligibility for HIP.
- The member's income increases over the HIP income standard.

A HIP member may disenroll from an MCE while retaining eligibility in the HIP program. Circumstances in which this occurs include the following:

- The member selects another MCE before making their initial contribution.
- The member selects another MCE during the MCE selection period, to be effective the following benefit period.
- The member's MCE disenrolls from the HIP program.
- The member is granted a change request because their request to change MCE due to just cause is approved by the state. See *Changing MCEs for Just Cause* for more details.

7.3 Healthy Indiana Plan Enrollment

HIP applicants have the opportunity to select an MCE. The applicant's plan selection is disregarded if the member was previously enrolled in the Right Choices Program. In this case, the member is automatically assigned to their last MCE.

MCEs assign their members to a PMP. Enrollees may self-select the MCE when they apply or are auto-assigned to the plan. The enrollment broker may help members select their MCE.

The MCE assignment effective date for HIP members will follow the same process as the other IHCP programs. That is, the DFR identified HIP eligibility effective date will be used as the MCE assignment effective date. There will be no gap when a member moves from one MCE to another.

After the DFR has determined that an individual is conditionally eligible, the individual's HIP conditional eligibility information is sent to the appropriate MCE via IEDSS and the 834 transaction from the fiscal agent. Within three calendar days of receiving the conditional eligibility file, the MCE must send a welcome letter and initial invoice notifying the individual that the first contribution is due within 60 calendar days of their conditional eligibility date or Fast Track date. The MCE must also send at least two reminders to individuals who have not made their first monthly contribution.

Except for members transitioning into HIP from other coverage who obtain a *HIP Basic* with *Potential Plus* segment, eligibility is not finalized for HIP until the individual makes their first contribution. If an individual pays the first contribution within 60 calendar days of their Fast Track date or conditional eligibility date, the MCE must notify IEDSS of the payment via the fiscal agent. IEDSS transmits fully eligible enrollment to the state fiscal agent, and the fiscal agent sends final eligibility to the MCE via the 834 transaction. This transaction also specifies the individual's effective date of coverage with the MCE. After the MCE receives the final eligibility information from the state fiscal agent via the 834 transaction, the individual is enrolled with the MCE effective the first date of the month in which the individual's payment was received by the MCE.

For example, if a member sends the HIP payment on October 27 and the plan submits the pay record on October 31, their assignment with the HIP program is effective October 1.

If the individual has household income greater than 100% FPL and fails to make their first *HIP Plus* contribution within 60 calendar days of their Fast Track date or conditional eligibility date when eligibility was submitted to the fiscal agent, then the MCE must notify IEDSS of the failure to pay via the daily pay/no pay file submitted to the fiscal agent. MCEs must not send conditional no-pay records on the monthly file. IEDSS then transmits a denial record to the state fiscal agent, and the fiscal agent sends final eligibility to the MCE via the 834 transaction. These individuals are determined ineligible for HIP, but are allowed to reapply through the DFR at any time. These individuals do not receive any preferential treatment and must go through the entire application process again.

If the individual has household income at or below 100% FPL and fails to make their first *HIP Plus* contribution within 60 calendar days of their Fast Track date or conditional eligibility date when eligibility was submitted to the fiscal agent, the MCE must notify IEDSS of the failure to pay via the daily pay/no pay file submitted to the fiscal agent. MCEs must not send conditional no-pay records on the monthly file. IEDSS then transmits an open record to the state fiscal agent for *HIP Basic*, and the fiscal agent sends final eligibility to the MCE via the 834 transaction. The member is not eligible to voluntarily transfer to *HIP Plus* until their annual redetermination period.

Generally, terminations are effective as of the last day of the month in which the triggering termination event occurred. If a member dies, the termination is effective on the date of death. The MCEs receive notice of member terminations via the 834 transaction.

HIP enrollment rosters also include:

- Member POWER Account contribution amount – The monthly amount owed by the member to be eligible to participate in the HIP program. Determined by the DFR, based on income.
- Emergency department copayment amount
- Member's specific HIP benefit group

- Any applicable eligibility flags (for example, Section 1931 parent or caretaker, medically frail, 19- or 20-year-old, and so forth)

7.4 Eligibility Verification

Enrollment transactions reflect members' status in *Core*MMIS as of the day the roster was produced. As explained earlier in this section, IEDSS eligibility is updated in *Core*MMIS daily. The eligibility verification options described in the following subsection are updated with the daily IEDSS information; therefore, they contain the most current eligibility status.

MCEs must advise providers to verify member eligibility *each time a service is rendered*. The most accurate way to verify eligibility is by using the member's name and date of birth or Social Security number, rather than the MID. This method provides the current MID. Failure to verify eligibility may result in a provider rendering services to an ineligible member. All EVS options provide an inquiry verification number that must be recorded in case it is required for subsequent transactions. MCEs must assume all telecommunication and hardware costs associated with these eligibility systems.

7.4.1 Eligibility Verification System

The EVS consists of three interactive, real-time options:

- The Provider Healthcare Portal
* The Interactive Voice Response (IVR) system
* The 270/271 HIPAA-compliant eligibility inquiry and response transaction

After the user enters the provider identification number, applicable provider identification requirements, the member's name and date of birth or Social Security number, and the *from* and *through* dates of service, eligibility information is transmitted online. The eligibility information includes the current MID, the name and telephone number of the member's PMP, along with the MCE's name, telephone number, network (if applicable), and network telephone number (if applicable). If the member is not linked to a PMP, the EVS indicates the PMP is not assigned.

7.4.2 Member Information Changes

The DFR is the official source of record for member demographic information. Members are required to report information changes to the DFR within 10 days. They may do so by updating their information on the online FSSA Benefits Portal, sending a written request to the FSSA document center or by calling 800-403-0864. Members that call the MCE to report income, address, or other demographic changes should be referred to the DFR. The DFR is the official source of record for member demographic information.

By referring members to the DFR for demographic information changes, the MCE is meeting the requirement to report changes and discrepancies in member demographic information about which they become aware (such as address changes, dates of death, and so forth) within 30 calendar days.

7.4.2.1 Member Address Changes

The preferred method for updating member addresses is to direct the member to submit an address update via the FSSA benefits portal. MCEs can instruct members to follow the steps below to submit an address update:

- Members select 'Report a Change' at https://fssabenefits.in.gov/bp/#/
- This allows the member to see their current address with DFR and to submit an address update that will be received electronically.

- This method should be used for all members who are comfortable with the online update process.

For members not comfortable with the benefit portal update process, authorized staff at the MCE should submit address updates via email to DFR. Authorized MCE staff include those that have been appointed as the contact person(s) for the DFR and have permission to request updates to member data. Address update requests should only be submitted following direct contact and verification with the member as outlined below.

- Unless a member provides verification, seeing an out-of-state provider or a provider (e.g., ER) providing a different address for the member should not result in the submission of an address update.
- When a new address is received from a provider, the member must be contacted to verify the address prior to submission to DFR.
- After the address change has been verified by the member, authorized MCE staff can submit address updates using a spreadsheet template. Data submitted on the spreadsheet should include: member's RID, first and last name, old and new address, current phone number, who in the household the address change impacts, an indicator showing if the move is out of state and the name of the MCE representative submitting the verified request.
- Address update requests should be sent to the Constituent Care email box at cc.fssa@fssa.in.gov. Only verified address update requests may be submitted to DFR by authorized MCE staff.

The MCE may also direct members to mail an address update request to the FSSA document center. The mailed request should include the new address, member first and last name, last four digits of the social security number, the new address and who in the household has moved. These requests should be mailed to: FSSA Document Center, PO Box 1810, Marion, IN 46952.

Warm transfer of members to the DFR call center for address updates is not recommended.

The MCE may report address discrepancies when a member calls and states they have already updated their address with the DFR via their Customer Service team reporting process, but the MCE system still reflects their previous address. System issues may be involved when the member states they have already updated their information with the DFR, and a file has not been received for an address change within 30 days.

The MCE is encouraged to periodically scan its systems to identify obvious errors, such as nonsensical addresses. The MCE should report nonsensical or erroneous addresses to the DFR via the Constituent Care email box at cc.fssa@fssa.in.gov. The MCE should no longer use *State Form 44151, Report of Change* to report this information. If discrepancies are found, MCE reports should contain the details of the change or discrepancy, including the member's ID, the member's name, as well as the means by which the MCE became aware of the change or discrepancy.

When the MCE identifies that a member may not reside in Indiana, the MCE shall attempt to make contact with the member to verify their residency and/or intent to return to Indiana. The MCE should report potential out-of-state residency if:

- An acceptable explanation is not given by the member.
* The member confirms that they have moved to another state, or
* No contact is made after three or more attempts.

The DFR will evaluate reported discrepancies against the DFR records and verify the accuracy of the information. If the need for a change is confirmed, the DFR will make updates to the member's file, which will in turn be relayed to *Core*MMIS. This update may be received through an address change or a closure file. A case does not need to be sent through review again. If fraud is suspected, the DFR will make a referral to the Bureau of Investigations and Benefit Recovery at that time. If a file is not received regarding any changes within 90 days of a change or closure, it means that the member confirmed a valid Indiana address, or the out-of-state mailing address was found to be allowable and the case will remain open. It is

also possible for a case to remain open while a fraud investigation has been opened but not yet resulted in prosecution.

It's important for MCEs to note the following regarding updating member addresses with DFR:

- Address updates can generate 2032 follow-up requests. The more information provided by the member, the less likely that DFR will have to follow up with the member.
- Information provided by the member should include (1) full names of everyone in the household that moved and (2) full names of anyone added to the household as result of the move.
- If the member is receiving any other benefits such as SNAP or TANF, additional follow up from DFR will be required.
- MCEs should encourage members to submit official change of address to USPS. The updated address information is received by DFR directly from the postal service.

Additional Citations

- IHCPPM 2220.00.00 – Individuals are given 10 days to report any changes to the DFR.
- * *42 CF 438.608(a)(3)* requires MCEs to notify the state of member address changes and dates of death.

7.4.2.2 Notification of a Member's Death

When the MCE becomes aware of a member's death, they must inform the DFR and include the member's:

- Full name
- Address
- Social Security number
- Member ID
- Date of death

The MCE has no authority to pursue recovery against the estate of a deceased IHCP member.

7.4.2.3 Suspected Fraud

The Family and Social Services Administration (FSSA) defines fraud as a false representation of a matter of fact, whether by words or by conduct, or by concealment of that which should have been disclosed, that is used for the purpose of misappropriating property and/or monetary funds from the FSSA. If prosecutable member fraud is suspected, the MCE may attempt to make contact with the individual to question the claim and verify if there is a valid explanation. The MCE should report potential fraud if they are unable to resolve questionable information. Reports can be sent to ReportFraud@fssa.IN.gov. FSSA will thoroughly and expeditiously investigate any reported cases of suspected fraud to determine if disciplinary, financial recovery, and/or criminal action should be taken.

7.4.3 Auto-Assignment

Members are auto-assigned in *Core*MMIS if they do not choose a plan. Auto-assignment considers prior plan, family relationships, and then a default process that considers plans by rotation.

*Core*MMIS first considers if the member was previously enrolled in the RCP and reassigns them to the previous Right Choices MCE immediately, effective on the first or 15th day of the month. Notwithstanding the foregoing, HIP eligibility is always effective on the first day of the month.

Exceptions are subject to immediate auto-assignment and are as follows:

* Members whose PRTF level of care (LOC) has ended
* HIP members who transfer to Hoosier Healthwise eligibility

*Core*MMIS checks the member's previous MCE assignment over a 12-month look-back period. In the absence of a previous MCE, *Core*MMIS looks for a member with the same case ID with an MCE assignment.

If a case ID cannot be matched, *Core*MMIS searches for a member with the same companion case ID who has an MCE assignment. Companion case ID is the mechanism IEDSS uses to link HIP families. The two programs do not share the same case ID in IEDSS. If a companion case ID is found, *Core*MMIS assigns the member to the same MCE. If companion case ID and MCE linkages are not found, *Core*MMIS uses default logic to make the assignment.

HIP-eligible members are assigned at the default level to an MCE on a target percentage basis. The state reserves the right to amend the auto-assignment logic and may incorporate Healthcare Effectiveness Data and Information Set (HEDIS) or other quality indicators into the auto-assignment logic at a future date.

After an assignment is made, *Core*MMIS transfers the assignment to the respective MCE as an Add record on the 834 Benefit and Enrollment transaction.

7.4.4 Preferred Medical Provider Selection

The MCE must ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs, and who is able to coordinate each member's physical and behavioral healthcare and make any referrals as required. Following a member's enrollment, the MCE must 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 must be assigned to a PMP within 30 miles of the member's residence.

If the member fails to initially select a PMP, the MCE shall assign the member to a PMP within 30 calendar days of the member's enrollment. The member must be assigned to a PMP within 30 miles of the member's residence, and the MCE must consider any prior provider relationships when making the assignment. The MCE's PMP auto-assignment process must comply with any guidelines provided and must be approved by state before implementation.

In assigning or auto-assigning a PMP, MCEs must:

- Authorize out-of-network care by any IHCP provider if panel slots are not available for the appropriate scope of practice within 30 miles of member's residence.
- Consider PMP assignment history (the fiscal agent provides 12 months of history; can also use MCE claims history)
- Consider provider panel limits
- Ensure provider scope of practice is considered
- Maintain lock-in PMP assignment when member is in the RCP

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

The MCE is required to notify the member in writing of the auto-assigned PMP provider. The notice must detail the member's right to change PMPs, including the process by which the member may change PMP.

7.4.5 Primary Medical Provider Assignment History File from Fiscal Agent to the Managed Care Entities

When a member is assigned to a new MCE, the fiscal agent sends the receiving MCE the member's prior 12 months of PMP history. The 12-month look-back is based on dates that are less than the start date of the new segment and fall within the previous 365-day time frame, regardless of how far in the future the placeholder assignment starts. For example, a placeholder created on February 3 for an effective date of March 1 starts counting 365 days backward from March 1. If the placeholder effective date is February 15, the countdown begins from February 15. This update to the logic therefore captures members affected by PMP disenrollment/re-enrollment.

This history is an electronic file that is posted to File Exchange. It is a proprietary file with limited historical information related to auto-assignment. The PMP Assignment History files are generated in response to placeholder assignments received from the MCEs. The assignment history files are not generated by regions like the 834s; one file generates per program when the process runs. The *PMP Assignment History* file layout is available on the *MCE Secure Landing* page at in.gov/medicaid/partners under *File Layouts* and by selecting *HIP Outbound*.

The member's PMP assignment history file includes the following information, from most recent to oldest:

* Member ID – 12 numeric characters
* PMP name – Up to 30 alphanumeric characters
* PMP Provider ID (LPI) – Nine numeric characters
* PMP group ID (Provider ID), if any – Nine numeric characters or eight numeric characters followed by one alpha character
* PMP location, group or individual – One alpha character
* PMP start reason
* PMP stop reason
* Effective date for each instance of a member's PMP linkage – Required, eight characters (CCYYMMDD)
* End date for each instance of a member's PMP linkage – Required, eight characters (CCYYMMDD)

PMP assignments must meet the following criteria to be captured on the PMP history file:

* The member changed MCEs during open enrollment
* The member changed MCEs for just cause
* The member had a gap in the IHCP eligibility and is now assigned to a different MCE than he or she was previously assigned
* Same-plan assignments may appear in this case if the member was assigned to the placeholder MCE before the member's last assignment with a different MCE, as long as the assignment is within the past 365 days.
* The member was assigned to another program under a different MCE.
* The member was assigned to another program under the same MCE (for example, the member is changing from HIP to Hoosier Healthwise under the same plan. The MCE IDs are different).

Assignments that are not captured are as follows:

* Members whose most recent assignment was with the same MCE, regardless of if there was a gap in coverage. MCEs must be aware of their prior members' history
* Members who have already been captured on the history file for a given placeholder assignment. These members do not make repeat appearances on subsequent file runs.

* Members who had a gap of more than 365 days with an MCE, even if that MCE is different than the one they have just been assigned

7.4.6 Primary Medical Provider Assignments from the Managed Care Entities to Fiscal Agent

MCEs must report PMP assignments to the fiscal agent so the information can be stored in *Core*MMIS. Providers see the member's PMP when verifying eligibility using the IHCP eligibility verification systems. MCEs must submit files for HIP PMP assignments. Files must be submitted by 6 p.m. daily, Monday through Friday. Only one file per day is processed. See *Primary Medical Provider Assignments from MCEs* for details about the file.

7.4.7 Changing Managed Care Entities

An individual may change their MCE selection at any time before making their first POWER Account contribution, or within 60 days of assignment to an MCE, whichever comes first, or during the MCE selection period from November 1 to December 15 each year (see *Changing Managed Care Entities During the MCE Selection Period*).

HIP members may also change their MCE selection at any time during the 12-month benefit period for just cause.

Just-cause reasons include, but are not limited to, the following:

- Poor quality care
- Failure of the MCE to provide covered services
- Failure of the MCE to comply with established standards of medical care administration
- Lack of access to providers experienced in dealing with the member's healthcare needs
- Significant language or cultural barriers
- Corrective action levied against the MCE by the state
- 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 healthcare needs
- Lack of access to medically necessary services covered under the MCE's contract with the state
- Services not covered by the MCE for moral or religious objections
- Related services are required to be performed at the same time but are not available within the MCE's network, and the member's primary medical provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- The member's PMP disenrolls from the member's current MCE and reenrolls with another MCE. In such an event, the member can change plans to follow their PMP to the new MCE.
- Other circumstances determined by the state or its designee to constitute poor quality healthcare coverage

Before the member contacts the Enrollment Broker (EB), the member must first contact their MCE, so the MCE can attempt to resolve the concern. If the member remains dissatisfied with the outcome, the member can contact the EB to request disenrollment. The EB reviews the request and makes a disenrollment determination.

The EB requests a copy of the member's grievance and appeals record from the MCE. The MCE is expected to respond to the EB's request within three (3) business days and provide the grievance number, date filed, reason and the member contact information. A complete grievance record must be submitted by the MCE to the EB within 30 days which includes the grievance number, date filed, reason, member contact information and a summary of actions taken (including the content of the resolution).

After the EB receives and reviews a copy of the member's grievance and appeals record from the MCE to confirm that the grievance and appeals process was exhausted, the EB makes a preliminary recommendation to the state about approving or denying the member's request. The EB must make the recommendation within 7 business days of receiving the complete grievance record. The state makes the final decision.

If the member's request is approved, the EB notifies the state fiscal agent about the member's disenrollment with MCE #1, and the member's new enrollment with MCE #2. The fiscal agent processes the member's disenrollment with MCE #1 and enrollment with MCE #2 via the 834 transaction concurrently, according to established procedures. During the member transfer, MCE #1 and MCE #2 must provide for continuity of care. During and after the member transfer, MCE #2 (the new plan) is responsible for answering any questions the member may have about the transfer. MCE #2 is also responsible for resolving any transition issues that may arise.

MCEs must detail the process for submitting disenrollment requests in its member handbook and on its member website. This information must include the following:

- Members may change MCEs for cause only during the 12-month coverage term. "For cause" is defined as receiving poor quality of care.
- Members are required to exhaust the MCE's internal grievance and appeals process before requesting an MCE change for poor quality of care.
- Members may submit requests to change MCEs to the EB verbally or in writing, after exhausting the MCE's internal grievance and appeals process.
- The MCE must provide the EB's contact information and explain that the member must contact the EB if the member has questions about the process. This information must include how to obtain the EB's standardized form for requesting an MCE change.

During the member transfer, MCE #1 and MCE #2 must provide for continuity of care. During and after the member transfer, MCE #2 (the member's new) is responsible for answering any questions the member may have about the transfer. MCE #2 is also responsible for resolving any transition issues that may arise. The member's rollover amount is moved through *Core*MMIS from MCE #1 to MCE #2.

HIP Basic and *HIP State Plan – Basic* members are also given the opportunity to change to *HIP Plus* or *HIP State Plan – Plus*, as applicable, at redetermination by paying their *Potential Plus* invoice.

7.4.8 Open Enrollment Period

A member letter is sent 60-90 days before end of the 12-month enrollment period. The letter advises that the member may choose a new MCE with an effective date on the first day following the end of their 12-month enrollment period. If the member does not choose to change MCEs, they stay enrolled with that MCE for the next 12 months. The data entry cutoff date is the 25th of each month. Changes are not accepted if they are requested after the last business day before the 25th day of the last month of the member's 12-month enrollment period. If the member chooses to change MCEs, they have a new 60-day free-change period beginning on the enrollment date with the new MCE.

7.4.8.1 Open Enrollment Scenarios

Open enrollment statuses include the following:

- No Status: Enrollment broker (EB) may make the initial self-selection health plan assignments for a member.
- Open Status (O): EB may make a health plan assignment change.

> ***Note:*** *A date segment accompanies this status, indicating when the member is in their 60-day free-change period.*

- Closed Status (C): EB may not make a health plan assignment change without just cause or a change in the household member health plan assignment.

> ***Note:*** *At the close of a member's 12-month enrollment, a date segment accompanies the closed status, indicating the date the member was assigned to the MCE and when the assignment period ends with their chosen MCE.*
>
> *With the closed status, the enrollment broker may make a future date assignment for the upcoming annual open enrollment period when the member is 60-90 days from the end of their closed status. A date segment accompanies the status when sent to the enrollment broker to help make the future date assignment.*

7.5 Assumptions

- Members become eligible for Medicaid the first day of the month.
- The DFR identified HHW eligibility effective date will be used as the MCE assignment effective date.
- Newborn children of MCE members have retroactive MCE assignment to the date of birth.
- Members who change MCEs during the 60-day free-change period or for just cause reasons are always effective with their new MCE enrollment on the first day of the month.
- Members continue to maintain the right to change PMPs within their MCE at any time.
- Members can maintain their PMP relationship if the PMP leaves the member's MCE after the 90-day free-change period has expired. For instance, if the PMP disenrolls with the member's current MCE but remains enrolled with another MCE, members can change MCEs to stay with their current PMP.
- Members cannot be locked into an MCE for more than 12 months.

The MCE selection period runs from November 1 until December 15 each year. Members may call the enrollment broker to select a new health plan. Health plan selections will be effective on the first day of the following benefit period (January 1). If a member transfers during the benefit period, MCE #1 must notify *Core*MMIS of the POWER Account rollover amount for which the member qualifies after the conclusion of the 120-day reconciliation period (even if it is zero). This notice must also detail any refund amounts due to the state.

7.6 Notification of Pregnancy

Early prenatal care can address potential health risks that contribute to poor birth outcomes. The state Neonatal Quality Committee, made up of Indiana health professionals, identified this as a focus area for prenatal care. The goal of the Notification of Pregnancy (NOP) initiative is to identify the health-risk factors of expectant mothers as early as the first trimester of pregnancy.

Within managed care programs, the FSSA uses the Notification of Pregnancy (NOP) form to improve the identification of health-risk factors of expectant mothers as early as the first trimester of pregnancy. NOPs

can be completed at any time during the managed care member's pregnancy, preferably during the initial visit, to document and monitor pregnancy conditions. If a managed care member's normal pregnancy becomes high-risk, providers should use the NOP to document the change.

7.7 Portal-Recognized Providers for Notification of Pregnancy

To submit and receive payment for an NOP, the member must be assigned to an MCE. Providers must be enrolled with the IHCP in one of the following specialties to submit and be reimbursed for the completion of the NOP form:

- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Obstetrician or gynecologist
- Neonatologist
- Certified nurse midwife
- Advanced practice registered nurse
- Federally qualified health center
- Medical clinic
- Rural health clinic
- Acute care hospital
- County health department
- Family planning clinic
- Nurse practitioner clinic

7.7.1 Notification of Pregnancy Process

To submit an NOP form, the recognized provider must access the NOP form using the Provider Healthcare Portal. A recognized provider verifies the member's eligibility through the portal. After logging on to the portal, the recognized provider selects the *Eligibility Inquiry* function to verify the member's eligibility. On verification, the recognized provider can complete the NOP form and electronically submit it via the portal. For technical assistance with the portal, the provider can contact the EDI Solutions Services Desk at 800-457-4584, option 3 then option 2.

If the recognized provider begins the NOP process and *Core*MMIS identifies that the NOP appears to be for the same member and the same pregnancy as a previously submitted NOP, the recognized provider must explain why the new NOP is not a duplicate. The recognized provider can continue the process; however, the duplicate NOP is not valid and is not eligible for reimbursement.

At completion of all NOP form sections, the recognized provider is prompted to ***Print NOP*** or ***Close***. A message that indicates whether the NOP is successfully submitted and eligible for reimbursement appears.

Successful submission results in an NOP that is determined *valid* or *conditional.*

Valid – An NOP that is not identified as being for the same member and the same pregnancy as a previously submitted NOP. Valid NOPs must be submitted by the recognized provider within 5 calendar

days of the date of service on the NOP form and must be for a member that was not 30 or more weeks pregnant on the date of service on the NOP form. Recognized providers are reimbursed $60 for successfully submitting a valid NOP.

Conditional – An NOP that is not identified as being for the same member and the same pregnancy as a previously submitted NOP but for which the recognized provider explained why this is a different pregnancy than the pregnancy covered by the previously submitted NOP. Conditional NOPs must be submitted by the recognized provider within five days of the date of service on the NOP form and must be for a member that was not 30 or more weeks pregnant on the date of service on the NOP form. Recognized providers are reimbursed $60 for successfully submitting a conditional NOP, as long as it is not later found to be not valid. The following three reasons are available for explaining why an NOP is not a duplicate:

- Member abortion
- Member preterm delivery
- Member miscarriage

Not Valid – An NOP that is identified as being submitted for the same member and the same pregnancy as a previously submitted NOP, submitted more than five calendar days from the date of service on the NOP form, or for a member who is 30 or more weeks pregnant on the date of service on the NOP form.

> ***Note:*** *Recognized providers are not reimbursed $60 for successfully submitting an NOP that is later determined not valid.*

The recognized provider that initiated and completed the NOP has access to the completed NOP through the portal. Any provider that matches its national provider identifier (NPI) or Provider ID to an NOP with any corresponding Member ID can view the submitted NOP at any time. The completed NOP can be printed any time after submission. After the NOP is submitted, the details cannot be amended or revised.

The NOP information form submitted by a recognized provider is sent to the appropriate MCE by File Exchange Protocol (FTP). The MCE uses the NOP data to begin the health risk assessment and determine the risk level associated with the member's pregnancy, and the need for prenatal care coordination. The MCE receiving the NOP is responsible for contacting the member to complete a comprehensive pregnancy health risk assessment within 21 days.

The MCEs stratify the member's risk level as being in one of three risk levels – high, medium, or low. The chosen risk level is returned to the state fiscal agent within 12 calendar days of the date the NOP was posted to the FTP. The MCEs receive $60 for each submitted NOP. The MCEs reimburse the recognized provider the full $60 per member, per pregnancy for each valid or conditional NOP submission. For each NOP completed and submitted, the state must deposit $40 into a birth outcomes bonus pool. The MCE may be eligible to receive a bonus payment from this fund as outlined in the MCE contract with the state.

The MCE may use methods other than a nurse or medical staff to complete the risk assessment. For example, the MCEs may build an algorithm to identify the risk level. The MCEs must also include other methods of identification of risk including (but not limited to) the following:

- Interactions with the pregnant member
- Contact with the physician
- Coordination with a prenatal care coordinator, if a relationship is already established

7.7.2 Notification of Pregnancy Form Requirements

Specific fields on the NOP form must be completed for successful form submission of a complete NOP form. Completion of the NOP form requires the recognized provider to check all fields specific to that member and pregnancy. A sample NOP form is available on the *Indiana Medicaid IHCP Provider's* page at

in.gov/medicaid/providers under *Clinical Services/Notification of Pregnancy Documentation*. The NOP Form must be accessed through the Provider Healthcare Portal. The recognized provider can print a blank PDF copy of the NOP form to complete by hand during the member's prenatal visit. The PDF version cannot be submitted electronically via the portal. Therefore, the information documented on the hardcopy form must be entered and submitted via the portal.

Prepopulated member data appears as determined in the Eligibility Verification System when the recognized provider completes the NOP through the portal. Prepopulated areas facilitate quick, accurate completion of the NOP form.

The following fields are required for the NOP to be considered valid:

At the header level:

- Date of service
- Provider Name (prepopulates after name selected from drop-down through the portal)
- NPI/Provider ID (prepopulates when completed through the portal)
- Provider Phone (prepopulates when Provider Name selected from drop-down through the portal)
- Person completing the form
- Member name (prepopulates when completed through the portal)
- Member address (prepopulates when completed through the portal)
- Member telephone number (prepopulates when completed through the portal)
- Date of birth and age (prepopulates when completed through the portal)
- Member ID (prepopulates when completed through the portal)
- Delivery system (prepopulates when completed through the Portal)
- Last Menstrual Period (LMP)
- Estimated Date Confinement (EDC)
- Number of weeks pregnant
- Current Tobacco user
- Other risk indicators
  - Obstetrical History
  - Medical History/Exam
  - Mental Health
  - Substance Abuse
  - Environmental/Social

7.7.3 State-Approved Training Documents and Forms

Other NOP state-approved training documents and instructions are also found at the *Medicaid for Providers Notification of Pregnancy* webpage.

7.7.4 Notification of Pregnancy Data Extracts

The NOP data extract automatically posts to File Exchange for each MCE on a daily basis. The process runs Monday through Friday at 6 a.m. Eastern Time (ET). Monday's run contains data from Friday, Saturday, and Sunday. The data extract runs for the prior full day's information and includes only the new

submissions or updates received since the last extract. The data extract is provided in XML format and includes member-specific information, applicable NOP information as populated by the recognized provider, and fiscal agent initial risk. Fields that are not populated by the recognized provider are omitted from the extract.

The system specifications and fields for this data extract, process flowchart, and schema XML format are available on the on the *File Layouts* page of the MCE-secure area of the IHCP business partners site at in.gov/medicaid/partners.

Each NOP form has a unique NOP ID. The NOP ID generates at the time the NOP is submitted. The MCE risk level is received and stored with the corresponding NOP ID. The date the MCE returned the first risk stratification is stored in the data extract as DATE_RECEIVED. The risk values are as follows:

- Fiscal Agent Initial – Stored on submission of NOP form and recorded by the fiscal agent. Risk level is High, Med, or Low.
- MCE Initial – This field is populated on initial receipt of the NOP XML file returned by the MCE. Risk level is High, Med, or Low.
- MCE Latest – This field is populated on receipt of NOP XML file returned by the MCE and used to store updated risk levels. Each receipt of updated risk level is an overlay to existing data. Risk level is High, Med, or Low.

7.7.5 Notification of Pregnancy Data Extract Risk Level Update File from MCEs to the Fiscal Agent

After the MCE receives the NOP data extract file, the MCE is required to complete and return to the fiscal agent a risk stratification for each NOP within-12 calendar days using the NOP Update XML format. The data extract includes the date sent (DTE_SENT field: Date fiscal agent posted to FTP), which starts the 12 - calendar-day time period. The MCE submits the following:

- NOP ID
- Risk Level (High, Medium, or Low)
    - NOP Submission
    - Delivery System
        - MDwise
        - MHS
        - Anthem
        - CareSource
        - FFS
    - NOP Status
        - Valid
        - Invalid
        - Suspect
    - Member Demographics Age:
        - Age
        - Under 15
        - 15-18
        - 19-25

    - 26-35
    - 36-45
    - 46-55
    - Over 55
- Member Demographics Race:
    - White
    - Black
    - American Indian
    - Asian
    - Other
- Member Demographics Ethnicity:
    - Hispanic
    - Non-Hispanic
- Member Demographics Primary Language:
    - English
    - Spanish
    - Other
- Number of Weeks Pregnant
    - 1-12 weeks
    - 13-27 weeks
    - 28 or more weeks
- Obstetrical – Top 10
    - Top five most selected as “Current”
    - Top five most selected as “History”
- Medical – Top 10
    - Top five most selected as “Current”
    - Top five most selected as “History”
    - Top five selections for those not current or history
- Previous Infant/Findings
    - Stillbirth > 28 wks.
    - Preterm birth < 30 wks.
    - Preterm birth 30-36 wks.
    - Birth weight < 2,500 gms
    - Birth weight < 4,000 gms
- Diagnosis of Pregnancy Risk
    - V22
    - V23
- Prenatal Vitamin Usage

    - Yes
    - No
- Body Mass Index
    - BMI > 30
    - BMI < 19
- Referrals
    - Indiana Family Helpline
    - Tobacco Quitline
    - WIC
    - Childbirth/Parenting
    - Domestic Violence
    - Mental Health/Substance Abuse
    - Prenatal Substance Use Prevention
- Psycho-Neurological History Clinical Depression:
    - History
    - Current
    - On Medication
- Psycho-Neurological History Postpartum Depression:
    - History
    - Current
- Psycho-Neurological History Suicide attempt/thoughts:
    - History
    - Current
- Psycho-Neurological History Borderline Personality Disorder:
    - History
    - Current
- Other
    - History
    - Current
- Substance Abuse/Use History
    - Marijuana
    - Amphetamine
    - Alcohol
    - Methadone
    - Cocaine/crack
    - Narcotics/heroin
    - Sedative/tranquilizer
    - Inhalants/glue

- Other
- Percent ready to quit next 30 days

- Tobacco History
  - Current use
  - Past 12 months
  - Percent ready to quit next 30 days
- Social Risk Factors Abuse:
  - Yes to one Question
  - Yes to two Questions
- Social Risk Factors Other:
  - Food Insecurities
  - Homeless in shelter
  - Transportation problems
  - Education < 10th grade
  - Learning Disability/MR
  - Rape
    - Current
    - History
  - Lives alone
  - Unemployed
  - No telephone
  - Unstable home
  - No family support

7.7.6 Provider Billing Guidelines

NOP information must be submitted via the Provider Healthcare Portal for the recognized provider to receive reimbursement for completing the NOP form.

Billing guidelines for NOP are as follows:

- NOP can be billed for HIP-enrolled members using procedure code 99354 with modifier TH and submitted to the MCE of record on the date of service.
- Recognized provider reimbursement for submission of a successfully submitted complete NOP is $60 per member, per pregnancy. Recognized providers must successfully submit a complete NOP via the portal within five calendar days of the date of service to be reimbursed. If the timeline is not met, the submission no longer qualifies for the $60 reimbursement. The date of service is the date the member risk assessment is completed by the recognized provider.
- Duplicate NOPs—those for the same member and the same pregnancy—do not qualify for $60 reimbursement. One NOP per member, per pregnancy is eligible for reimbursement. Recognized providers receive a systematic message if the NOP appears to be a duplicate. Recognized providers may continue to complete the NOP or cancel the NOP for that pregnant woman.
- NOPs for pregnant members at 30 weeks of gestation or more are not eligible for the $60 reimbursement.

7.7.7 High-Risk Pregnancy Payment and Notification of Pregnancy

To document medically high-risk pregnancies for HIP members, providers must complete and submit the NOP through the portal. The NOP is the only acceptable method of documentation for high-risk pregnancies; the Prenatal Risk Assessment Form or other standardized risk-assessment tools are no longer accepted forms of documentation. IHCP will reimburse for high-risk pregnancy care when provided by physicians or advanced practice registered nurses (APRNs).

For members who are determined high risk after 30 weeks of gestation, the provider must complete an NOP for the High Risk Modifier to be paid. As previously mentioned, NOPs completed after 30 weeks of gestation cannot receive the $60 reimbursement. Also, for those members for whom an NOP form has already been completed, the High Risk Modifier will normally work regardless of the stratification of the NOP. The provider must always have documentation available to prove the pregnancy was high risk in the event of an audit.

7.7.8 Capitation

The MCE capitation payment process runs on the normal capitation cycle, the third Wednesday of every month, and is included in the 820 MCE Capitation Payment Transaction. The NOP payments are identified by the capitation code of NH (Package H NOP Payment). Payment reasons codes are PN (Normal Payment) or RN (Recoupment – Notification of Pregnancy).

The following scenarios prevent a capitation payment to the MCEs:

- The NOP submission is considered duplicate (the same member and the same pregnancy as a previously submitted NOP).
- The fiscal agent does not have a risk stratification on file from the MCE when the capitation cycle is generated.
  - If the MCE returned the risk stratification more than 12 calendar days from the date the NOP XML file was posted to the FTP site, the state must review and approve the exceptions before processing.
- The NOP was submitted by the recognized provider more than 5 calendar days from the date of service.
- The NOP was submitted by the recognized provider for a member30 or more weeks pregnant on the date of service.
- The MCE submitted a risk stratification for an NOP ID that is not found in *Core*MMIS.

7.7.9 Newborn Prebirth Selection

Pregnant members' MCEs coordinate PMP preselections for newborn members. *Core*MMIS retroactively assigns newborns to their respective mothers' MCEs as soon as the newborns' eligibility is passed from IEDSS to *Core*MMIS. The MCE must notify *Core*MMIS of the newborn's PMP using the PMP assignment input file.

7.8 Provider-Initiated Requests for Member Reassignment

The HIP program encourages positive and continuous relationships between members and PMPs. In rare instances, a PMP may request reassignment of a member to another PMP within the MCE. The MCE must approve and document these situations. The reasons for these situations include the following:

- Missed appointments (with appropriate documentation and criteria).

- Member fraud (upper-level review required).
- Uncooperative or disruptive behavior on the part of the member or member's family (upper-level review required).
- Medical needs that could be better met by a different PMP (upper-level review required).
- Breakdown in physician and patient relationship (upper-level review required).
- The member accesses care from providers other than the selected or assigned PMP (upper-level review required).
- Previously approved termination.
- Member insists on medically unnecessary medication.

The MCE's medical director or a committee appointed by the medical director performs an *upper-level review* – a thorough review of the individual case – to determine whether the cause and documentation are sufficient to approve a reassignment. The upper-level review includes monitoring to improve the overall quality of the program and to ensure that the MCE's guidelines and policies are consistent with those of the program.

Guidelines for the situations outlined previously are as follows:

- Missed appointments – A member may miss at least three scheduled appointments without defensible reasons before a PMP may request member reassignment. The PMP or staff is responsible for educating the member, on the first occurrence, about the problems and consequences associated with missed appointments. Missed appointments must be documented in the member's chart that is accessible to the PMP and staff. On documentation of the third missed appointment for nondefensible reasons, the MCE may approve the PMP's request for the member's reassignment within the MCE.

  MCEs are encouraged to have procedures in place to assist members and PMPs with missed appointments and are expected to intervene as required to resolve issues, while supporting the overall goals of the HIP program.
- Member fraud – This reason for member reassignment must be restricted to cases referred to the Indiana Bureau of Investigation or the Office of the Inspector General (OIG).
- Threatening, abusive, or hostile actions by members – The PMP can request a member's reassignment when the member or the member's family becomes threatening, abusive, or hostile to the PMP or to the office staff after attempts at conflict resolution have failed. The request must be consistent with the PMP's office policies and with criteria used to request reassignment of commercial patients. The MCE must have conflict resolution procedures designed to address these concerns.
- Member's medical needs may be better met by another PMP – A PMP may request member reassignment because the PMP believes a member's medical needs would be better met by a different PMP. This request must document the severity of the condition and must be reviewed by the MCE's medical director. The MCE's medical director must review the request based on the specific condition or severity of the condition as a PMP scope-of-practice matter, not based on a bias against an individual member.
- Breakdown of physician and patient relationship – The MCE must conduct an upper-level review, as defined previously, to ensure that the breakdown in the relationship between the PMP and the member is mutual.
- Member accessing care from other than the selected or assigned PMP – The MCE must conduct member education about the health plan and the PMP selection process. If the member does not initiate a PMP change and continues to access primary care services from a provider other than the PMP, the PMP may request the member's reassignment. Misuse of the emergency department is not a valid reason for requesting a member's reassignment.

Most of these situations can be resolved by facilitating the member's selection of another PMP within the health plan. Members who require services of providers not available within the health plan generally are not disenrolled but remain in the MCE, with the MCE managing and reimbursing for out-of-network services.

MCEs must use PMP-initiated requests for member reassignments to identify issues and concerns documented in quality improvement processes. Each MCE must develop an internal policy for approval of PMP-initiated member reassignments, based on the criteria outlined previously. Unacceptable reasons for PMP-initiated member reassignment requests:

- For good cause – This term is used for member-initiated PMP change requests.
- Noncompliance with mutually agreed-to treatment – Members are not reassigned for being noncompliant or refusing treatment. A patient has the right to refuse treatment.
- Demand for unnecessary care – A PMP-initiated request for member reassignment is not approved for this reason unless there is documentation of threatening, abusive, or hostile behavior, as described.
- Language and cultural barriers – PMPs who have difficulty with a member's language or other cultural barriers must request assistance from the MCE to address the problem.
- Unpaid bills incurred before HIP enrollment – PMPs may not initiate member transfer requests because of unpaid medical bills incurred before HIP enrollment. PMPs can pursue charges outstanding before HIP enrollment through the normal collection process.

7.9 New Member Materials

Within five calendar days of a new member's full enrollment, the MCE must send new members a *Welcome Packet* based on the State's model enrollee handbook. The *Welcome Packet* must include, but is not limited to, a new member letter, explanation of where to find information about the MCE's provider network, and a copy of the member handbook. For HIP members, the *Welcome Packet* must also include a Medicaid ID card. The Medicaid ID card must include the member's MID and the applicable cost share information such as emergency services copayment and other co-payment amounts.

The *Welcome Packet* must also include information about selecting a primary medical provider (PMP), completing a health screening, and any unique features of the MCE. For example, when the MCE provides incentives to members for completing a health screening, a description of the member incentive must be included in the *Welcome Packet*. The MCE can use the health assessment to determine the member's health such as medically frail, etc. The Welcome Packet must also include educational materials about the POWER Account and POWER Account rollover, member required cost sharing, non-payment penalties, as well as the recommended preventive care services for the member's benefit year.

7.9.1 General Information Review, Approval and Requirements

The MCE must develop, and include, an MCE-designated inventory control number on all member promotional, education, or outreach materials with *date issued* or *date revised* clearly marked. The purpose of this inventory control number is to facilitate the state's review and approval of member materials and to document its receipt and approval of original and revised materials. The MCE must keep a log of all member materials used during the year and must submit its member handbook to the state annually for review.

The MCE must submit all marketing, promotional, educational, and outreach materials to the state for review and approval at least 30 calendar days before the materials' expected use and distribution. The MCE must get the state's approval to use or display program logos each time the MCE wishes to do so. The MCE must not assume the state will approve using the logo just because the state has previously approved the

logo's use. The MCE must obtain the state's approval before distributing or using materials. The state shall assess liquidated damages or other remedies if the MCE uses or distributes unapproved member materials.

All state-approved member and potential member communication materials must be available on the MCE's provider website within three business days of distribution.

The MCE must produce member materials and may distribute member materials only if they are approved by the state and compliant with *42 CFR 438.10*. If the state requests, then the MCE must provide information about how the materials are used for member education and enrollment.

This information may include, but is not limited to, the following:

- A provider directory listing the MCE's providers and identifying each provider's specialty, service locations, hours of operation, telephone numbers, public transportation access, and other demographic information, in accordance with *42 CFR 438.10(f)(6)(i)*.
- MCE member bulletins or newsletters issued not fewer than four times a year that provide updates related to covered services and access to providers.
- Updated policies and procedures specific to the HIP population.
- MCE telephone system scripts and commercials-on-hold.
- MCE-distributed literature about all health or wellness programs the MCE offers.
- The MCE's marketing and promotional brochures and posters.
- A member handbook that describes the terms and nature of services offered by the MCE and contact information, including the MCE's website address.

The MCE must make written information available in English and Spanish and other prevalent non-English languages, as identified by the state, at the member's request. The MCE must identify additional languages that are prevalent among members, inform members that information is available on request in alternative formats, and tell members how to obtain alternative formats. The state defines alternative formats as Braille, large-font letters, audiotape, prevalent languages, and verbal explanations of written materials. The MCE must offer braille as an alternative format for receiving member materials. When a member has requested materials in braille, the MCE must supply future materials in braille to the member. The MCE may review with the member the specific documents types the member wishes to receive in braille versus other formats. The MCE may outreach to members to inquire if braille documents are still the desired format. To the extent possible, written materials must not exceed a fifth-grade reading level.

The MCE must notify its members of the respective programs' covered services that the MCE does not cover on moral or religious grounds and must offer guidelines for how and where to obtain those services, in accordance with *42 CFR 438.102.* The MCE must provide this information to members before and during enrollment, and within 90 calendar days after adopting the policy with respect to any particular service.

The MCE must inform members that, at a member's request, the MCE provides information on the structure and operation of the MCE and, in accordance with *42 CFR 438.6(h)*, provides information on the MCE's provider incentive plans.

The MCE is responsible for developing and maintaining member education programs designed to offer members clear, concise, and accurate information about the MCE's program, the MCE's provider network, and the HIP program. The state encourages the MCE to incorporate community advocates, support agencies, health departments, other governmental agencies, and public health associations in its outreach and member education programs. The state also encourages the MCE to develop community partnerships with these types of organizations to promote health and wellness within its membership.

7.9.2 Electronic Communications

The MCE must provide an opportunity for members to submit questions or concerns electronically, via email, and through the member website. If a member's email address is required to submit questions or concerns electronically to the MCE, then the MCE must help the member establish a free email account.

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

The MCE must have reporting capability for email communications received and responded to, such as total volume and response times. The MCE must be prepared to provide this information to the state on request.

The MCE shall collect information on member's preferred mode of receipt of MCE-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 MCE 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 MCE shall send the notice by regular mail within three business days of the failed email. When applicable, the MCE 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 MCE Policy and Procedure manual.

As required by 42 CFR 438.10(c)(6)(i)-(v), 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.

7.9.3 Website

The MCE must provide information to members through an Internet website in a state-approved format, compliant with *Section 508* of the *US Rehabilitation Act,* to ensure compliance with existing accessibility guidelines. The website must be live and meet the requirements of this section on the effective date of the contract. The state must preapprove the MCE's website information and graphic presentations. The website

must be accurate and current, culturally appropriate, written at a fifth-grade reading level, and available in English and Spanish. The MCE must inform members that information is available in alternative formats on request and advise how to request another format. To minimize download and wait times, the website must 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 MCE must date each webpage, change the date with each revision, and allow users print access to the information. Such website information must include, at minimum, the following:

- MCE's searchable provider networks for HIP – Identifying each provider's specialty, service locations, hours of operation, telephone numbers, public transportation access, and other demographic information
- Updates to the online provider network information at least every two weeks
- Contact information for member inquiries, member grievances, or appeals
- Member services telephone number, telecommunications device for the deaf (TDD) number, hours of operation, and after-hours access numbers
- Member portal with access to electronic explanation of benefits (EOB) statements
- Member portal access to up-to-date POWER Account balance information, including the required annual and monthly contribution amounts and payments made
- Preventive care and wellness information, including information about the preventive care services covered under the preventive care benefit and the preventive care services that qualify a member for POWER Account rollover
- Information about EPSDT and the MCE's prenatal services.
- Information about the cost and quality of healthcare services
- A list of covered benefits and services by program
- Wellness and prevention programs or prenatal services
- Description of the MCE's disease management programs
- Marketing brochures and posters
- Notification letters to members regarding MCE decisions to terminate, suspend, or reduce previously authorized covered services
- Telephone system scripts and commercials-on-hold
- MCE-distributed literature regarding all health or wellness promotion programs offered by the MCE
- Member's rights and responsibilities
- HIP member handbooks
- *Health Insurance Portability and Accountability Act (HIPAA*) Notice of Privacy Practices
- Links to the state's website for general Medicaid or HIP information
- Link to the preferred drug list and pharmacy locations
- Transportation access information.
- Information about access to carved-out services
- Information about access to dental services and contact information for questions
- Secure and confidential premium payment information
- A list and brief description of each of the MCE's member and provider outreach and education materials
- Executive summary of the *MCE's Annual Quality Management and Improvement Program Plan Summary Report*
- Information on behavioral health covered services and resources

- A secure portal through which members may complete the health needs screen questionnaire
- Information on the annual Open Enrollment period from November 1 to December 15, where members may make a new MCE selection for the next calendar year

7.10 Member Information, Outreach and Education

The MCE must provide the information listed in this section within a reasonable period, following notice from the state fiscal agent of the member's enrollment in the MCE. This information must be included in the member handbook. In addition, the MCE must notify members at least once per year of their right to request and obtain the information listed in this section. If the MCE makes significant changes to the information provided under this section, then the MCE must notify the member in writing of the intended change at least 30 calendar days before the intended effective date of the change, in accordance with *42 CFR 438.10(f)* The state defines significant changes as any changes that may affect member accessibility to the MCE's services and benefits.

The MCE's educational activities and services must also address the special needs of specific HIP subpopulations (such as pregnant women, at-risk members, and medically frail members), as well as its general membership. The MCE must demonstrate how these educational interventions reduce barriers to healthcare and improve health outcomes for members.

The MCE must 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 MCE must provide information requested by the state, or the state's designee, for use in member education and enrollment, on request.

As required by 42 CFR 438.10(d)(3), the MCE 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.

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

For first-time or one-time requests from a member, the Contractor shall mail the alternate 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.

The MCE must comply with the requirements of *42 CFR 422.128* for maintaining written policies and procedures for advance directives with respect to all adult individuals receiving medical care by or through the MCE's health plan. Specifically, each MCE must 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 healthcare, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of healthcare when the individual is incapacitated."

Written information about the MCE's advance directive policies, including a description of applicable state law, must be provided to members, in accordance with *42 CFR 438.10(g)(2)* and *42 CFR 438.10(d)*. Written information must reflect changes in state law as soon as possible, but no later than 90 calendar days after the effective date of the change. Each MCE must provide written information to those individuals with respect to their rights under state law, and the MCE's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See *42 CFR 422.128(b)* for further information regarding this requirement.

The MCE must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the state.

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).

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

Grievance, appeal, and fair hearing procedures and time frames must be provided to members in accordance with *42 CFR 438.10(g)(2)(xi).* See the Member Notices of Grievance, Appeal and Fair Hearing Procedures section for further information about grievance, appeal, and fair hearing procedures, as well as the kind of information the MCE must provide to members.

7.10.1 Member Communications - Returned Mail

MCEs are responsible for tracking returned member mail. MCEs must have policies and procedures in place regarding handling and processing of returned mail. The MCE shall outreach to the member for each piece of returned mail to verify the mailing address. Outreach consists of at least one call to verify the mailing address.

If the MCE makes contact with the member and verifies that the mailing address has changed, MCEs need to report the change as outlined in the Member Information Changes section of this Manual.

If the MCE finds that the mailing address provided on the 834 does not match the DFR information or the member confirms they have already updated their address with DFR, the MCE should submit an updated

address request to the OMPP Member Services team. The OMPP Member Service team can request that a reseed from IEDSS be sent to *Core*MMIS so the updated address is sent to the MCE on the 834 file.

7.10.2 Member Handbook

The MCE must develop a member handbook for HIP members. The MCE may choose to develop a separate member handbook for the HIP line of business. The MCE's member handbook must be submitted annually for the state's review. 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). The member handbook must include the MCE's contact information and Internet website address, and describe the terms and nature of services offered by the MCE, including the following information required under *42 CFR 438.10(c)(6)*.

The HIP member handbook must include the following:

- MCE's contact information (address, telephone number, TDD number, and website address)
- The amount, duration and scope of services and benefits available under the Contract in sufficient details to ensure that participants 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
- Procedures for selecting and changing PMPs
- Information about the EPSDT benefit and ow to access services within and outside the MCE
- The procedures for obtaining benefits, including authorization requirements
- Information on accessing transportation, including how it is provided for any carved-out benefits per 42 CFR 438.10(g)(2)(i)
- MCE's office hours and days, including the availability of a 24-hour nurse call line
- 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
- The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under *42 CFR 438.10(f)(6)(viii)*, such as what constitutes an emergency condition or service, the fact that prior authorization is not required for emergency services, and that the member has a right to use any hospital or other setting for emergency case
- The post-stabilization care services rules set forth in *42 CFR 422.113(c)*
- The extent to which, and how, urgent care services are provided
- Applicable policy on referrals for specialty care and other benefits not provided by the member's PMP, if any
- HIP pregnancy policies including, but not limited to, a description of the *HIP Maternity* program and the enhanced services available to the member
- HIP cost-sharing policies including, but not limited to, termination for non-payment or transfer to *HIP Basic*. terminations
- HIP tobacco surcharge for members who use tobacco
- HIP copayments for emergency department services, and the ability to receive a waiver by calling the 24-hour nurse call line prior to utilizing a hospital emergency department
- Information about the availability of pharmacy services and how to access pharmacy services
- Member rights and protections, as enumerated in *42 CFR 438.100*, which relates to member rights. See Section 7.8 for further detail regarding member rights and protections.
- Responsibilities of members

- Special benefit provisions (for example, copayments, deductibles, limits or rejections of claims) that may apply to services obtained outside the MCE's network
- Procedures for obtaining out-of-network services
- Standards and expectations to receive preventive health services
- Policy on referrals to specialty care
- Explanation that the member is not required to obtain a referral before choosing a family planning provider
- Procedures for notifying members affected by termination or change in any benefits, services or service delivery sites, including access to the MCE's transition of care policy and how to access continued services upon transition per 42 CFR 438.62
- Procedures for appealing decisions adversely affecting members' coverage, benefits or relationship with the MCE, including, but not limited to a medically frail determination
- 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 because of one of the "for cause" reasons described in *42 CFR 438.56(d)(2)(iv)*, including, but not limited to, the following:
  - Poor quality of care
  - Failure of the MCE to provide covered services
  - Failure of the MCE to comply with established standards of medical care administration
  - Lack of access to providers experienced in dealing with the member's healthcare needs
  - Significant language or cultural barriers
  - Corrective action or immediate sanctions levied against the MCE by the Office of Medicaid Policy and Planning (OMPP), per 42 CFR 438.56(c)(2)(iv)
  - 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 healthcare needs
  - Lack of access to medically necessary services covered under the MCE's contract with the state
  - A service is not covered by the MCE for moral or religious objections, as described in Section 9.3.3
  - Related services for a condition are required to be performed at the same time, and not all related services are available within the MCE's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk
  - Disenrollment of member's primary healthcare provider from the member's current MCE and re-enrollment with another MCE
  - 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
  - A change in aid category; or
  - Other circumstances determined by the OMPP or its designee to constitute poor quality of healthcare coverage
- Policies and processes for submitting disenrollment requests, including the following:
  - HIP members may only change MCEs (i) for cause, (ii) prior to either making their initial POWER account contribution or Fast Track prepayment or (iii) during MCE selection period.
  - Members are required to exhaust the MCE's internal grievance and appeals process before requesting an MCE change because of poor quality of care.

  - 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.
  - 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, including instructions on how to obtain the enrollment broker's standardized form for requesting an MCE change.
- The process by which American Indian/Alaska Native members 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
- Procedures for making complaints and recommending changes in policies and services
- Grievance, appeal, and fair hearing procedures as required at *42 CFR 438.10(g)(2)(xi)*, including:
  - The right to file grievances and appeals
  - Requirements and timeframes for filing a grievance or appeal
  - 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: (i) benefits will continue if the member files an appeal or requests a state fair hearing within the specified timeframes; and (ii) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.
- 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
- Information about how to exercise advance directives
- How to report suspected fraud or abuse
- How to report a change in income, change in family size, and so forth
- How to request a medically frail determination during the benefit year
- 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)
- 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
- Information on how to contact the enrollment broker
- Statement that MCE will provide information on the structure and operation of the health plan
- In accordance with *42 CFR 438.10(f)(3),* that upon request of the member, information on the MCE's provider incentive plans will be provided
- Information on the annual open enrollment period from November 1 to December 15 where members may make a new MCE selection effective the next calendar year
- Information on the tobacco surcharge

7.10.3 Preventive Care Information

The MCE is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care 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. The plans must include reminders that encourage members to obtain the state-recommended preventive care 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 14.6 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.

7.10.4 POWER Account Education

The MCE must establish a variety of methods, approved by the state, to educate members about their POWER Accounts. The MCE must emphasize those features of POWER Accounts that help members stay healthy, be value- and cost-conscious, and use services in a cost-efficient manner. The MCE must explain the impact members' health-seeking behavior has on their ability to use leftover POWER Account balances to reduce the next benefit period's required POWER Account contribution. The MCEs must also explain the member's right to obtain partial refund of their POWER Accounts if they leave the HIP program.

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

- Employers' and other third parties' opportunity to contribute to member POWER Accounts
- Nonpayment policies, including:
  - 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 60 calendar days of its due date
  - Inability for members transferred to *HIP Basic* to obtain *HIP Plus* benefits until the member's next redetermination period
  - HIP debt policies
  - Forfeiture of 25% of remaining member share of the POWER Account contributions
- Policies regarding how members may report a chance in income or family size that may impact their eligibility or benefits
- POWER Account rollover policies and obtaining recommended preventive care for *HIP Plus* and *HIP Basic*
- POWER Accounts may not be used to pay for *HIP Basic* copayments or required copayments

7.10.5 Managed Care Entity Member Services Helpline

The MCE must maintain a statewide toll-free telephone helpline for HIP members who have questions, concerns, complaints and requests for PMP changes. The same helpline shall be available to MCE members, so that members may call one number to answer all the family's questions.

The MCE must staff its member services helpline to provide sufficient live-voice access to its members during, at a minimum, a 12-hour business day from 8 a.m. to 8 p.m. Eastern time, Monday through Friday. The MCE shall provide a voice message system that informs callers of the MCE's business hours and offers an opportunity to leave a message outside of business hours. Calls received in the voice message system must be returned within one business day.

The member services helpline must offer language translation services for members whose primary language is not English and must offer telephone-automated messaging in English and Spanish. A member services messaging option must be available after business hours in English and Spanish. The MCE must provide 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 staff must respond to all members' messages by the end of the next business day. If the MCE's member services helpline number or function changes, then the MCE must notify the state and the fiscal agent's Care Programs operations manager about those changes.

The MCE call centers are authorized to close on the following holidays:

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

Additionally, each MCE may request that additional days, such as the day after Thanksgiving, be authorized for limited staff attendance. This request must be submitted to the state at least 30 days in advance of the date being requested for limited staff attendance and must be approved by the state.

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.

Member services helpline staff must be trained in both the Hoosier Healthwise and HIP programs to ensure that member questions and concerns are resolved as quickly as possible. The MCE must also give their helpline staff the ability to transfer members directly to outside entities. This includes, but is not limited to, the enrollment broker, the DFR, the general HIP hotline, provider offices, and, when appropriate, the fiscal agent.

The MCE must ensure the warm transfer of calls for members that require attention from a MCE 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, or other member services staff, must be returned by the next business day.

The MCE must maintain a system for tracking and reporting the number, type of member calls, and the inquiries received during business hours and nonbusiness hours. The MCE must monitor its member services helpline and report telephone service performance to the state on a regular basis. The MCE's member services helpline staff must be prepared to respond to member concerns or issues including, but not limited to, the following:

- Access to healthcare services
- Identification or explanation of covered services
- Special healthcare needs
- Procedures for submitting a member grievance or appeal
- Potential fraud or abuse
- Changing PMPs
- POWER Accounts and POWER Account balances
- HIP benefit packages
- POWER Account contributions including initial payment due dates, and non-payment penalties
- Incentive programs

- Disease management services, care management and complex case management services
- Recommended age- and sex-appropriate preventive services
- Transfers between Hoosier Healthwise and HIP coverage
- Employer or other third-party POWER Account contributions
- Balance billing issues
- Participating in clinical studies of special healthcare needs as directed by the state
- Referrals to local services or community-based organizations for assistance; and
- Health crises, including but not limited to suicidal callers.

7.10.6 Health Needs Screen and Comprehensive Health Assessment

MCEs must conduct a health-needs screen (HNS) for new members who enroll in their plan. The HNS helps identify the member's physical, behavioral, and special healthcare needs, and identifies members who might need disease management, case management, or care management services. The HNS may be conducted in person, by telephone, online, or by mail. The state encourages the MCEs to conduct the screening at the same time the PMP selection outreach occurs.

The MCE must use the standard health-screening tool developed by the state, the HNS. The MCE is permitted to supplement the state HNS with additional questions. Any additions to the state HNS must be approved by the state.

The MCEs are responsible for conducting an HNS for all new members. For purposes of the health screening requirement, new members are defined as members that have not been enrolled in the MCE's plan in the previous 12 months. The HNS must be conducted within 90 calendar days of a new member's enrollment in the MCE's plan. The MCE is encouraged to conduct the HNS at the same time it assists the member in selecting a PMP. The MCE is also required to conduct a subsequent HNS when a member's healthcare status is determined to have changed since the original screening, such as evidence of overuse of healthcare services identified through such methods as claims review.

All screener questions are REQUIRED and must be asked of all members, depending on question-related rules, such as gender specific, age range, and follow-up based on response.

The MCE nonclinical staff may conduct the HNS. The results of the HNS must be transferred to the state in the form and manner required by the state. Data from the HNS or NOP form, current medications, and self-reported medical conditions are used to develop stratification levels for members in HIP. While the MCE may use its own proprietary stratification methodology to determine which members must be referred to specific disease management programs, ranging from member detailing to care management, the state applies its own stratification methodology which may, in future years, be used to link stratification level to the per member, per month capitation rate.

Sometimes, the initial screening indicates that the member has a special healthcare need or requires follow-up. In this case, the initial health screening must be followed by a detailed health assessment by a healthcare professional followed up by a detailed Comprehensive Health Assessment Tool (CHAT). The detailed health assessment may include, but is not limited to, discussion with the member, a review of the member's claims history, and contact with the member's family or healthcare providers. These interactions must be documented and available for review by the state. The MCE must keep up-to-date records of members with special healthcare needs, based on the initial screening, including documentation of the detailed health assessment and contacts with the member, their family, or healthcare providers.

7.10.7 Health Needs Screen Extract

MCEs must submit a monthly extract of completed HNS by the 15th of every month. The monthly file should contain assessments completed in the previous month that were done within the 90-day timeframe. The time period being reported should include the first day of the previous calendar month through the last day of the previous calendar month. MCE's are required to include any late records with their following month's submission. MCEs should only submit HNS that are considered to be complete. The definition of "complete" is an assessment that has at least 11 of the 13 questions answered and was completed within the required 90-day timeframe.

Extracts should be placed at state's SFTP location in the respective MCE folder.

7.10.8 Members with Special Healthcare Needs

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

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

- Conducting the initial screening and more detailed health assessment to identify members 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, the state, 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 the state issues related to children with special healthcare needs, including grievances and appeals data
- Participating in clinical studies of special healthcare needs, as directed by the state
- Advising of members’ rights

The MCE must guarantee the following rights protected under *42 CFR 438.100* to its members:

- The right to receive information, in accordance with *42 CFR 438.10*
- The right to be treated with respect and due consideration for their dignity and privacy
- The right to receive information about available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- The right to participate in decisions regarding their healthcare, including the right to refuse treatment
- 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 pertaining to the use of restraints and seclusion
- The right to request and receive a copy of their medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in *45 CFR* parts 160 and 164, subparts A and E
- The right to be furnished healthcare services, in accordance with *42 CFR 438.206* through *438.210*

The MCE must also comply with other applicable state and federal laws regarding member rights, as set forth in *42 CFR 438.100(d)*. The MCE must have written policies in place regarding the protected member rights listed previously.

The MCE must have a plan in place to ensure that its staff and network providers consider member rights when furnishing services to the MCE's members. Members must be free to exercise protected member rights. The MCE must not discriminate against a member who chooses to exercise their rights.

7.10.9 Cost and Quality Information

The MCE must make cost and quality information available to members to encourage more responsible use of healthcare services and educated healthcare decision-making. Example cost information includes average cost of common services, urgent versus emergent care costs, and so forth.

For services which may be at risk for improper payments, the MCE must develop processes to verify with members that said targeted services billed by providers were actually received by said members, to obtain direct verification of services rendered and increase oversight. MCE's processes must be identified in *MCE's Program Integrity Plan*.

The MCE shall provide explanations of benefits (EOBs) to all members on a monthly basis, at minimum. EOBs shall be available via paper and secure web-based portal. EOBs shall be delivered to members based on their preferred mode of receipt of MCE communications. At a minimum, EOBs shall be designed to address requirements in *42 CFR § 433.116(e)* and *(f)*, and *455.20*. To maintain member confidentiality, EOBs shall not be sent on family planning services. The EOB statements must indicate when services are paid with POWER Account funds. POWER Account statements and EOB information may be combined in a single statement. The MCE must give HIP members an opportunity to receive email alerts about EOB information on the member's secure web portal, in addition to receiving the information by mail.

The MCE must capture quality information about its network providers and must make this information available to members. In making the information available to members, the MCE must identify any limitations of the data. The MCE must also refer members to quality information compiled by credible external entities, such as Hospital Compare, Leap Frog Group, and so forth.

7.11 Redetermination Assistance

MCEs may assist members in the eligibility redetermination process, and are permitted to do the following:

- Conduct outreach calls or send letters to members reminding them to renew their eligibility and reviewing redetermination requirements with the member.
- Answer questions about the redetermination process.
- Help the member obtain required documentation and collateral verification needed to process the application.

While providing assistance during redetermination, MCEs are not permitted to do the following:

- Discriminate against members, particularly high-cost members or members who have indicated a desire to change MCEs
- Talk to members about changing MCEs; questions about changing MCEs should be referred to the enrollment broker.
- Provide any indication about the member's eligibility; questions about eligibility should be referred to the DFR.
- Engage in or support fraudulent activity associated with helping the member complete the redetermination process

- Sign the member's redetermination form
- Complete or send redetermination materials to the DFR on behalf of the member

MCEs must provide redetermination assistance equally across their membership and be able to demonstrate to the state that their redetermination procedures are applied consistently.

Eligibility redetermination for Healthy Indiana Plan (HIP) members occurs at intervals determined by the Division of Family Resources (DFR). HIP members must renew their eligibility every 12 months.

Managed care entities (MCEs) may assist members in the redetermination process but must offer the same level of assistance to all members. Members are ultimately responsible for completing redetermination materials, signing the redetermination form, and submitting these materials to the DFR by the required deadline.

7.11.1 Eligibility Redetermination

The DFR uses the same process to verify information contained in redetermination forms as it does for original applications. Although MCEs are permitted to assist members in the redetermination process, the DFR must make all final redetermination decisions. After receiving a member's completed redetermination materials, the DFR determines whether the member is eligible for HIP for another coverage term.

Redetermination of member eligibility in HIP by the DFR occurs every 12 months and is based on criteria set forth by the state. Members' redetermination and eligibility period are no longer tied to the benefit period. The benefit period for every member is from January 1 to December 31. A member's redetermination for HIP occurs at the end of their 12-month eligibility period. This could occur in any month and is different for each member.

The state recalculates the member's state Personal Wellness and Responsibility (POWER) Account contribution based on any changes in the member's income recognized during redetermination. A member's POWER Account (PAC) obligation may increase, decrease, or remain the same. A member's PAC may also change during the year if they experience a change in income. If a member is *HIP Basic/HIP State Plan Basic* and has an increase in income following completion of their redetermination, they will receive a *Potential Plus* segment and have an opportunity to buy up to *HIP Plus* benefits.

Approximately 45 days prior to the end of the member's eligibility, they will be notified of any documentation needed to determine continued eligibility. Members who do not return required information before the end of the eligibility period will be disenrolled but will have 90 days to reenroll without a new application if they provide the requested information.

7.11.2 Soft Close

A soft close is the 90-day period that members have to comply with redetermination and return requested documents. The 90-day clock starts from the date the member lost coverage. It is called a soft close because the member has the entire 90 days to return requested documents. Any new applications will be processed but not sent to Core Medicaid Management Information System (*Core*MMIS) or the MCE until the member is conditionally approved and eligible for HIP. This means soft close members will not be Fast Track-eligible and their earliest start date would be the month they are conditionally approved. All members, including exempt populations, have 90 days to comply without reapplication (or with reapplication) and therefore are subject to soft close rules until required documents are returned to become conditionally approved/eligible.

Table 23 provides several examples of how a member would be subject to a soft closure depending on their compliance with requests for documentation:

Table 23 – Soft closure Example Scenarios

Member Example 1 (Complies by Due Date)	**Member Example 2** (Complies before eligibility period ends)	**Member Example 3** (Complies within 90 Days)	**Member Example 4** (Does not comply but reapplies within 90 Days)	**Member Example 5** (Does not comply but reapplies and pays within 90 Days)
Member applies for HIP and begins their eligibility period 1/1/2018	Member applies for HIP and begins their eligibility period 1/1/2018	Member applies for HIP and begins their eligibility period 1/1/2018	Member applies for HIP and begins their eligibility period 1/1/2018	Member applies for HIP and begins their eligibility period 1/1/2018
Member receives notice of redetermination in October 2018	Member receives notice of redetermination in October 2018	Member receives notice of redetermination in October 2018	Member receives notice of redetermination in October 2018	Member receives notice of redetermination in October 2018
There is a due date to turn in documentation by 12/14/18	There is a due date to turn in documentation by 12/14/18	There is a due date to turn in documentation 12/14/18	There is a due date to turn in documentation by 12/14/18	There is a due date to turn in documentation by 12/14/18
Member turns in Documents 12/13/18	Member will not continue after eligibility period ends	Member does not turn in information before 12/31/18 and begins 90 day clock to comply	Member does not turn in information before 12/31/18 and begins 90 day clock to comply	Member does not turn in information before 12/31/18 and begins 90 day clock to comply
Redetermination is complete and member's coverage continues without a gap	Member turns in Documents 12/29/18	Member turns in documents on 1/25/19 – after due date but within 90 days after eligibility period end date	Member reapplies on 4/5/19	Member reapplies on 4/5/19 and makes a fast track payment (even though not fast track eligible due to 'soft lockout')
	Redetermination is complete and member's coverage will be *reinstated* without a gap	Member is conditionally approved by DFR and able to reenroll in HIP program	Member turns in eligibility information – and is conditionally approved 4/27/19. Member pays 4/29. HIP Plus 4/1/19	Member turns in information – and is approved 5/7/19. Member will start HIP Plus 5/1/19

7.11.3 Member Appeals Ineligibility Decision at Redetermination

A member may appeal a determination of ineligibility. The member has 33 days following the effective date of a notice of discontinuance of coverage to file the appeal with the Office of Administrative Law Proceedings. However, if the member would like to maintain coverage without change until the administrative law judge (ALJ) issues a decision, the appeal must be filed before their coverage terminates. If the appeal is filed before the member's coverage terminates, the MCE must continue to provide coverage for the member through the pendency of the appeal. If a member was terminated for nonpayment before being denied eligibility, the appeal would be of the nonpayment termination. In these cases where the appeal concerns nonpayment of a Power Account contribution, the member does not qualify for continued benefits coverage during the appeal, even if the member appeals before their coverage termination date.

7.11.3.1 Timely Appeal

If a member appeals within the required timeframe, a new eligibility period is established for the member until a determination can be made regarding the member's appeal; therefore, a member who timely appeals is given a new 12-month benefit period. This eligibility period could be modified after the ALJ's decision is rendered to comply with the ALJ's decision. If the appeal decision has not been made before the member's benefit period ends, the member is required to complete their redetermination. A member who timely appeals discontinuance because of not paying their POWER Account contribution is not entitled to a continuation of benefits pending appeal.

The MCE receives an 834 from the state fiscal agent that shows the member as eligible for 12 additional months of eligibility. This benefit period runs subsequent to the terminated benefit period.

The MCE establishes a new POWER Account for the member's new benefit period. The MCE needs to complete rollover calculations as normal at the 120-day mark for the previous benefit period. The state

makes its contribution to the new POWER Account via the state fiscal agent. The state fiscal agent continues to pay capitation to the MCE for each month the member is fully eligible in appeals.

During appeals, the member needs to continue to make POWER Account contributions to remain eligible for *HIP Plus* or *HIP State Plan Plus*, as applicable. The MCE continues to bill the member. If the member has 60 days of nonpayment, the MCE submits a nonpayment trigger to IEDSS and the member is terminated from HIP or transferred to *HIP Basic* or *HIP State Plan Basic*, as applicable.

All routine member communications and services (for example, preventive services reminders, redetermination packets, billing, claims payment, and so forth) continue.

If the member's timely appeal is granted:

- The member's new or appealed benefit period continues. The MCE does not receive any additional information on the 834.
- The MCE needs to reconcile any debt or penalty that was charged to the member, as the member has continued to pay their monthly contributions, and the termination was made in error. No penalty or debt can be applied.

If the member's timely appeal is denied:

- The member's benefit period is terminated at the end of the month of the ALJ's resolution and the member is liable for any claims paid on their behalf by the MCE during the appeals period. As the member must not have had coverage during the appeals period, the MCE may recoup any payments made to providers on behalf of the member while the member was in appeals. It is then the provider's responsibility to pursue payment from the member.
- The MCE completes the termination calculations (including debt and penalty, if applicable) and reports them to the state fiscal agent on the POWER Account Reconciliation File (PRF), in accordance with policies and procedures.

7.11.3.2 Untimely Appeal

If a member does not appeal the eligibility determination by the time their current eligibility period is completed, the member is not given a new benefit period while in appeals. The MCE receives a termination notice via the 834 and must process it according to standard operating procedures.

If the member's untimely appeal is granted:

- The MCE receives an 834 with a retroactive eligibility period (similar to MCE transfers).
- A new 12-month benefit period is established that begins at the time the termination occurred.
- The MCE receives capitation payments for all months that are reinstated and assigned to that MCE.
- All claims for HIP covered services that the member incurred during this time frame may be resubmitted by the provider for payment.
- The member must pay the remaining portion of their individual required contribution in equal installments throughout the remainder of the member's current benefit period. If the member fails to make these installments or becomes 60 days' delinquent in payments, the member is terminated for nonpayment, or transferred to *HIP Basic* or *HIP State Plan Basic*, as applicable.
- The MCE needs to reconcile any debt or penalty that was charged to the member, as the member has continued to pay their monthly contributions, and the termination was made in error. No penalty or debt can be applied. The member's remaining balance may be adjusted in lieu of refunding money.

If the member's untimely appeal is denied:

- The member's termination is final, and the MCEs complete the 60- and 120-days' calculations as with any termination. Penalty and debt may apply to these situations.

7.11.4 Changing Managed Care Entities During the MCE Selection Period

7.11.4.1 MCE Lock-In and Selection Period

Ongoing HIP members have an opportunity to change MCEs every fall between November 1 and December 15 during the MCE selection period. Postcards will be sent to members throughout the month of October to inform them of the new Open Enrollment period. If a member does not wish to change MCEs, he or she will not need to take any action and will automatically stay with their current health plan for the new year. A member wishing to change MCEs may do so by calling the enrollment broker (877-GET-HIP-9) by December 15. All health plan changes will be effective January 1 and stay in effect for the *calendar year*.

When invoicing members for January POWER Account payments, MCE notices will advise members who change health plans they may receive two invoices – one from their old plan and one from their new plan. Members will be instructed to make January POWER Account payments only to their new health plan. Any member who incorrectly pays the old MCE for a January contribution will be refunded by that MCE. The member will not be reassigned to the old health plan as a result of the payment error.

Members will no longer change their health plan when they go through eligibility redetermination. Redetermination will still occur for each member every 12 months. Eligibility redetermination offers members a chance to upgrade from *HIP Basic* by buying into *HIP Plus* coverage with POWER Account contributions.

If the member contacts the enrollment broker and selects a new MCE, the enrollment broker must notify *Core*MMIS*,* according to established procedure.

During the member transfer, the original MCE (MCE #1) and the new MCE (MCE #2) must provide for continuity of care. During and after the member transfer, MCE #2 is responsible for answering any questions the member may have about the transfer. MCE #2 is also responsible for resolving any transition issues that may arise.

MCE #1 must still notify the state fiscal agent of the rollover amount (even if it is zero) that the member qualifies for after the conclusion of the 120-day reconciliation period. This notice must also detail any amounts to be refunded to the state. The member's rollover amount is moved by the state fiscal agent from MCE #1 to MCE #2.

Examples of Calendar Year Lock-In

The following table describes calendar year lock-in.

Table 24 – Calendar Year Lock-In Examples

Member Example 1	Member Example 2	Member Example 3	Member Example 4	Member Example 5
Member has HIP with Anthem until 4/30/18	Member has HIP with Anthem until 4/30/18	Member has HIP with Anthem until 4/30/18	Member has HIP with Anthem until 10/31/18 when they close over income	Member applies for HIP and begins their eligibility period 1/1/2018
Member moves out of Indiana but returns in June	Member moves out of Indiana but returns in June	Member moves out of Indiana but returns in June	Member reapplies 1/2/19 and picks/pays Caresource	Member receives notice of redetermination in October 2018
Member (or Navigator) applies for 6/3/18 but does not pick an MCE or pay	Member (or Navigator) applies for 6/3/18 –picks Caresource	Member (or Navigator) applies for 6/3/18 – picks/pays Caresource	Member is approved 1/25/19 and is HIP Plus 1/1/19 with Caresource	There is a due date to turn in documentation by 12/14/18
Member will be assigned Fast Track and/or Conditional with Anthem	Member is already assigned to Anthem for 2018 – and will be Fast Track and/or Conditional with Anthem	Member is already assigned to Anthem for 2018 – and will be Fast Track and/or Conditional with Anthem		Member does not turn in information before 12/31/18 and begins 90 day clock to comply
	Member pays 7/5/18 and is Plus with Anthem 7/1/18	Caresource will refund payment. Member will need to pay Anthem to begin Plus coverage		Member reapplies on 4/5/19 and makes a fast track payment (even though not fast track eligible due to 'soft lockout')
	Member calls to change to Caresource on 11/29/18 for 1/1/19.	Member pays 7/3/18. HIP Plus with Anthem 7/1/18		Member turns in information – and is approved 5/7/19. Member will start HIP Plus 5/1/19
		Member calls to change to Caresource on 11/29/18 for 1/1/19.		

7.11.4.2 MCE Lock-In and Selection Period for Cause

In addition to the current just cause process for a member to change MCEs, there will be an additional "for cause" process directed at a member who was unable to participate in the MCE selection time. If a member was unable to participate because of being in a different IHCP program or not being fully open in HIP, they may call and select a new MCE within 30 days of starting in HIP.

Members who call and indicate that they were not able to participate in MCE selection do not have to appeal to their MCE as a first step, nor do they have to follow the standard just cause process. They may simply call the enrollment broker and indicate that they were unable to pick an MCE. The enrollment broker reviews the case in *Core*MMIS to confirm that the member meets one of the following scenarios, and if confirmed, allows the member to select a new MCE. The MCE change will be effective the first of the following month.

7.11.4.2.1 Lock-In Example Scenarios

Scenario 1

Member transitioned from other IHCP program to HIP. The enrollment broker can confirm in *Core*MMIS when the HIP eligibility segment began and that the member was previously in a different contiguous IHCP segment. In this case a member must call within 30 days* of the start of their HIP eligibility segment. This can occur at any point in the calendar year.

Example 1

Anthem Hoosier Care Connect 11/1/17-5/31/18.

Anthem *HIP Basic*+ 6/1/18 – on going

Member calls 6/25/18 to change to MDwise

EB changes member to show 7/1/18 with MDwise

Time to pay does not change based on change

Example 2

Anthem Hoosier Care Connect 11/1/17-5/31/18.

Anthem *HIP Basic*+ 6/1/18 – on going

Member calls 7/2/18 to change to MDwise

EB does not change the member – 30 days has passed.

Scenario 2

Member has a previous MCE but is not fully eligible during MCE selection time (for example, member reapplies in fall and is assigned previous MCE). Since member is then authorized (COND) for coverage in November/December they may not become fully eligible in time to participate in MCE selection. MAXIMUS can confirm in *Core*MMIS that the member was not fully eligible in HIP during the time postcards for MCE selection were mailed and therefore did not have a chance to participate. This would apply for a member who became fully eligible in November or December, allowing them to call by January 31 to choose a new MCE and qualify for a no-appeal transfer.

Example 1

CareSource *HIP Plus* 1/1/18-8/31/18

Member reapplies for HIP 11/3/18

Member goes COND with CareSource

Member wants to change to MDwise but cannot because they are not fully eligible

Member pays CareSource 12/20/18

CareSource sends pay file 12/30/18 and member opens *HIP Plus* 12/1/18.

Member calls to change to MDwise on 1/14/19

EB will change member to MDwise 2/1/19

Example 2

CareSource *HIP Plus* 1/1/18-8/31/18

Member reapplies for HIP 11/3/18

Member goes COND with CareSource

Member wants to change to MDwise but cannot because they are not fully eligible

Member pays CareSource 12/20/18

CareSource sends pay file 12/30/18 and member opens *HIP Plus* 12/1/18.

Member calls to change to MDwise on 2/7/19

EB will not change member – 30 days has passed

7.12 Member-Provider Communication

According to *42 CFR 438.102*, the MCE must not prohibit or restrict a healthcare professional from advising a member about their health status, medical care, or treatment options as long as the professional is acting within their lawful scope of practice. This provision does not require the MCE to provide coverage for a counseling or referral service if the MCE objects to the service on moral or religious grounds.

In accordance with *42 CFR 438.102(a)*, the MCE must allow health professionals to advise the member on alternative treatments that may be self-administered and provide the member with any information needed to decide among relevant treatment options. Health professionals are free to advise members on the risks, benefits, and consequences of treatment or nontreatment.

The MCE must not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods. The MCE may not take punitive action against a provider that requests an expedited resolution or supports a member's appeal.

7.13 Member Inquiries, Grievances and Appeals

The MCE must have written policies and procedures governing the resolution of grievances and appeals. At a minimum, the grievance system must include a grievance process, an appeal process, expedited review procedures, external review procedures, and access to the state's fair hearing system. The MCE's grievances and appeals system, including the policies for recordkeeping and reporting grievances and appeals, must comply with *42 CFR 438*, Subpart F, as well as *IC 27-13-10* and *IC 27-13-10.1* [when the MCE is licensed as a health maintenance organization (HMO)] or *IC 27-8-28* and *IC 27-8-29* (when the MCE is licensed as an accident and sickness insurer).

In compliance with 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 438.492(c)(1)(i)-(ii) and 42 CFR 438.408.

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 43 8.400(b)*, is an expression of dissatisfaction about any matter other than an *action* as defined previously. 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 failure to respect the member's rights. All grievances are appealable under *IC 27-13-10-7* and *27-13-10-8*.

The term *appeal* is defined as a request for a review of an action. An *action*, as defined in *42 CFR 438.400(b*), is the following:

- 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
- Failure to provide services in a timely manner, as defined by the state
- Failure of an MCE to act within the required time frames
- Denial of a member to exercise their right, under *42 CFR 438.52(b)(2)(ii)*, to obtain services outside the network when the member resides in a rural area with only one MCE

- Denial of a member's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

The MCE must notify the requesting provider, and give the member written notice, of any decision considered an *action* taken by the MCE, including any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of *42 CFR 438.404*. See *Authorization of Services and Notices of Action* for additional information.

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 file grievances orally or in writing.

The MCE's policies and procedures governing grievances must include provisions that allow for the following filing, notice, and resolution time frames:

- Members must be allowed to file grievances verbally or in writing within 60 calendar days of the occurrence that is the subject of the grievance. Members may file a grievance regarding any matter other than those described in the definition of an action.
- The MCE must acknowledge receipt of each grievance within three business days. The MCE must make a decision on non-expedited grievances as expeditiously as possible, but not more than 30 calendar days following receipt of the grievance. This time frame may be extended up to 14 calendar days if resolution of the matter requires additional time. If the time frame is extended, for any extension not requested by the member, the MCE must give the member written notice of the reason for the delay. The MCE must provide the member with a written notice of any extension within 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 MCE appeals process must accomplish the following:

- Allow members, or providers, acting on the member's behalf, 60 days from the date of action notice to file an appeal according to Indiana Administrative Code (*LSA Document #11-724*). A provider, acting on behalf of the member and with the member's written consent, may file an appeal.
- In accordance with 42 CFR 438.406, the MCE must ensure that verbal requests seeking to appeal an action are treated as appeals. For oral appeals with expedited resolutions the MCE shall maintain documentation of the oral appeal and its resolution. As of March 1, 2020, oral requests no longer need to be followed by a written request.
- Acknowledge receipt of each standard appeal within three business days. The MCE must make standard, non-expedited, appeals within 30 calendar days of receipt of the appeal. This time frame may be extended up to 14 calendar days, pursuant to *42 CFR 438.408(c)*. If the time frame is extended, for any extension not requested by the member, the MCE must give the member written notice of the reason for the delay.
- Maintain an expedited review process for appeals when the MCE, 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. The MCE must dispose of expedited appeals within 48 hours after the MCE receives notice of the appeal, unless this time frame is extended, pursuant to *42 CFR 438.408(c)*. In addition to the required written decision notice, the MCE must make reasonable efforts to provide the member with verbal notice of the disposition of the appeal.
- If the MCE denies the member's request for an expedited resolution of an appeal, then the MCE must transfer the appeal to the standard 30 calendar-day time frame and give the member written notice of the denial within two days of the expedited appeal request. The MCE must also make a reasonable attempt to provide prompt verbal notice to the member.
- The MCE must acknowledge receipt of each standard appeal within three business days.
- The MCE must make standard, non-expedited, appeal decisions within 30 calendar days of receipt of the appeal. This period may be extended up to 14 calendar days, pursuant to *42 CFR 438.408(c)*.

The MCE's policies and procedures governing appeals must include provisions that address the following:

- The MCE must not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member, in accordance with *42 CFR 438.102*. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.
- The MCE must not take punitive action against a provider that requests or supports an appeal on behalf of a member.
- The MCE must consider the member, representative, or estate representative of a deceased member as parties to the appeal throughout the appeals process.
- The MCE must allow the member and member representative an opportunity to examine the member's case file, including medical records, and any other documents and records.
- The MCE must allow the member and member representative to present evidence, and allegations of fact or law, in person as well as in writing.
- The MCE must ensure that there is no delay sending the appeal decision to the member and member's representative. The MCE's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a state fair hearing, the process for filing a fair hearing, and other information set forth in *42 CFR 438.408(e)*.
- The MCE must notify members of the disposition of grievances and appeals pursuant to *IC 27-13-10-7* (if the MCE is licensed as an HMO) or *IC 27-8-28-16* (if the MCE is licensed as an accident and sickness insurer).
- The MCE must 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.
- The MCE must ensure that the individual rendering the decision on grievances and appeals were not involved in previous levels of review or decision-making and 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 an expedited resolution of an appeal; or (iii) any grievance or appeal involving clinical issues.

In accordance with *IC 27-13-10.1-1* and *IC 27-8-29-12*, the MCE must 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. An external review does not inhibit or replace the member's right to appeal an MCE decision to a state fair hearing.

Within 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 MCE's decision by an independent review organization (IRO). Within 72 hours, for an expedited appeal, or 15 business days for a standard appeal, the IRO will render a decision to uphold or reverse the MCE's decision. The determination made by the independent review organization is binding on the MCE.

An independent external review of an authorization denial must be performed by an approved independent review organization (IRO). The Indiana Department of Insurance (IDOI) maintains a list of approved IROs to be used by MCEs for independent external reviews. MCEs and other health maintenance organizations in the state are required to rotate through the list of IDOI-approved IROs before using an IRO again. For each requested independent external review, the MCE must select the next IRO on the list to perform the review, unless the subsequent IRO vendor is unable to fulfill the request, in which case that IRO may be skipped.

In accordance with *42 CFR 438.408*, the state maintains a fair hearing process that allows members the opportunity to appeal the MCE'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 following requirements:

- The member may request an FSSA fair hearing within 120 calendar days of exhausting the MCE's internal procedures according to the Indiana Administrative Code *(LSA Document #11-724*).
- The parties to the FSSA fair hearing must include the MCE, as well as the member and their representative or the representative of a deceased member's estate.
- If dissatisfied with the outcome of the state fair hearing, the member may request an agency review within 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 MCE's discretion.
- The MCE must include 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 MCE 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
      402 W. Washington St., Room E034
      Indianapolis, IN 46204

In certain member appeals, the MCE is required to continue the member's benefits pending the appeal, in accordance with *42 CFR 438.420*. The MCE shall continue the member's benefits if:

- The member or provider files the appeal within 10 days of the MCE mailing the notice or the intended effective date, 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, the benefits shall be continued until one of the following occurs:

- The member withdraws the request;
- 10 days passes after the MCE has mailed the notice of an adverse decision, unless a state fair hearing and request for continuation of benefits until state hearing is resolved is requested within these 10 days, or
- The time period or service limits of a previously authorized service(s) has been met.

If the final resolution of the appeal is adverse to the member, that is, it upholds the MCE's action, the MCE 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* and *42 CFR438.420*. The MCE must notify the member in advance that costs may be recovered. The MCE may arrange for the member to pay back any such amounts owed in monthly installments, not to exceed four months.

The MCE must authorize or provide disputed services promptly, and as expeditiously as the member's health condition requires if the services were not furnished while the appeal was pending and the MCE or the FSSA fair hearing officer reverses a decision to deny, limit, or delay services.

The MCE must pay for disputed services, in accordance with state policy and regulations, if the MCE or the FSSA fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending.

7.13.1 Member Notice of Grievance, Appeal and Fair Hearing Procedures

The MCE must provide specific information about member grievance, appeal, and state fair hearing procedures and time frames to members, as well as to providers and subcontractors when they contract with the MCE. The information provided must be approved by the state and, as required under *42 CFR 438.10(g)(1)*, include the following:

- The right to file grievances and appeals
- The requirements and time frames 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 telephone
- The fact that, if requested by the member and under certain circumstances, the following will occur:
  - Benefits will continue if the member files an appeal or requests an FSSA fair hearing within the specified time frames.
  - 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 External Review by an Independent Review Organization
- The FSSA fair hearing information must include the following:
  - The right to a hearing
  - The method for obtaining a hearing
  - The rules that govern representation at the hearing

7.14 Oral Interpretation Services

The MCE must provide free verbal interpretation services to its members seeking healthcare-related services in a provider’s service location, in accordance with *42 CFR 438.10 (d)*. The MCE must notify its members of the availability of these services and how to obtain them.

The requirement to provide oral interpretation applies to all non-English languages and is not limited to prevalent languages. Oral interpretation services must include sign-language interpretation for the deaf.

Additionally, the MCE must 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 24-hour access to healthcare-related services in their service locations or via telephone (for example, hospital emergency departments, PMPs) shall provide members with 24 hour oral interpreter services, either through interpreters or telephone services. For example, the MCE must ensure that network providers provide TDD services for hearing impaired members, oral interpreters, and signers.

7.15 Cultural Competency

In accordance with 42 CFR 438.206(c)(2), the MCE 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 438.204, at the time of enrollment with the MCE, the state shall provide the race, ethnicity, and primary language of each member. This information shall be utilized by the MCE to ensure the delivery of care in a culturally competent manner. The MCE must incorporate the Office of Minority Health's National Standards on *Culturally and Linguistically Appropriate Services* (CLAS) into the provision of healthcare services for its members.

7.16 Managed Care Entity Application Assistance and Distribution to Nonmembers

The state permits contracted vendors in the HIP program to distribute applications to the general community but forbids them from acting as a state employee or a choice counselor of applicants. According to federal regulations, no cold-call marketing is allowed. The state defines cold-call marketing as any unsolicited personal contact by the MCE with a potential enrollee for the purpose of selling, promoting, surveying, or soliciting a state-sponsored health insurance plan.

> ***Note:*** *The term **applicant** in this document refers to non-Medicaid members who are applying for state Medicaid assistance.*

MCEs must abide by all federal regulations when outreaching and must obtain approval from the state before distributing any materials to members or potential members. The MCE must give the FSSA a written request and submit a draft at least 30 calendar days before the distribution of materials through the established document review process. On the cover sheet, the MCE must indicate if the materials are distributed at outreach events for Medicaid applications.

The MCE must ensure that the distribution of the state Medicaid application abides by the following requirements:

- MCEs cannot act as agents of the state or represent themselves as state caseworkers.
- MCEs may hand out applications at outreach events such as health fairs. MCEs are not permitted to be enrollment centers or act as qualified providers (QPs) for Presumptive Eligibility (PE). MCE satellite offices or permanent distribution areas are not permitted to distribute applications.
- MCEs cannot allow an applicant to authorize the MCE to act as the applicant's representative or to act on behalf of the applicant.
- MCEs may distribute Indiana Health Coverage application forms.
- MCEs may not distribute *State Form 48552 (7-98) Pending Verification*; *Change Request* form; or the *Authorization for Release of Information (State Form 44150 (R5/7-99).*
- MCEs may set up an area with a table, chair, clipboard, and writing utensils, where members can fill out applications.
- MCEs must not indicate whether the member is eligible; this decision must be made by the DFR.
- MCEs will not sign the member's forms.
- MCEs will not influence MCE selection; if members are unsure about which MCE to choose, MCEs must refer them to the enrollment broker.
- MCEs may not keep the applicant's completed application or submit the application. The applicant can leave the application at a state-registered enrollment center.

7.17 SNAP Alignment Language

MCE documentation that refers to Supplemental Nutrition Assistance Program must receive a secondary review through the Department of Family Resources (DFR). If the MCEs use the aligned language below, documentation submissions will not require the secondary review. The MCE must still submit the document for approval following the normal document approval process.

1. What is SNAP?
    a. SNAP stands for the Supplemental Nutrition Assistance Program. SNAP previously was known as food stamps. SNAP is a benefit that helps people and families buy food to stay healthy.
    b. SNAP helps low-income and no income people and families buy nutritious food. SNAP benefits are loaded on an Electronic Benefits Transfer (EBT) card. The EBT card can be used like a debit or ATM card at the grocery store.
    c. With your SNAP benefits you can buy food like bread, cereal, fruit, vegetables, and meat. You can also buy plants or seeds that grow food.
    d. Amazon, Walmart, and ALDI let you order food online with your SNAP EBT card and have it delivered (fees may apply).
    e. SNAP can help you buy healthy food and support your budget!
    f. To learn more about SNAP food assistance, visit in.gov/fssa/dfr/snap-food-assistance.
2. How to apply
    a. You apply for SNAP benefits by completing an application. You can apply for SNAP online, by mail, by fax, or in person at your county Division of Family Resources (DFR) office.
    b. To apply online or print an application visit fssabenefits.in.gov
    c. To find your county office visit in.gov/fssa/dfr/2999.htm
    d. You can call 800-403-0864 to have an application mailed to you.
    e. After you apply for SNAP DFR will contact you for an interview. This interview will determine your eligibility for SNAP.
    f. Applying for SNAP is easy!

        You can apply for SNAP benefits through the FSSA Benefits Portal, www.fssa.benefits.in.gov, by:

        - Filling out an online application.
        - Printing and mailing the application.
        - Asking for a paper application by mail.

        You can also apply by calling DFR at 800-403-0864. Call today to get started.
3. Am I eligible for SNAP?
    a. Your household could be eligible for SNAP benefits. If you apply, the Division of Family Resources will determine your eligibility for SNAP.

b. To qualify for SNAP, you must meet certain income and asset requirements.

c. If your income is below the monthly limit, and you have $5,000 or less in assets (like a bank account) you may be eligible for SNAP. Check your eligibility by calling 800-403-0864 or online at fssabenefits.in.gov.

d. You can visit, in.gov/fssa/dfr/snap-food-assistance/do-i-qualify-for-snap to see if you qualify for SNAP.

To learn more and apply, you can contact your local Division of Family Resources (DFR) office at 800-403-0864 or online at fssabenefits.in.gov

Section 8: Provider Network Requirements

Managed care entities (MCEs) contracting with the Family and Social Services Administration (FSSA) to administer the Healthy Indiana Plan (HIP) program are required to develop and maintain a comprehensive provider network for the provision of covered services to their members. MCEs must also be enrolled in *Core*MMIS. In addition to supporting capitation and claims processing functions, MCE enrollment in *Core*MMIS allows the MCE to submit, through the Portal, the Indiana Health Coverage Programs (IHCP)-enrolled primary care providers participating in the MCEs' HIP program.

8.1 Managed Care Entity Enrollment in *Core*MMIS

MCEs are required to complete the *MCE Enrollment Form*, available on the *Miscellaneous MCE Documents* page of the Managed Care Health Plan restricted site at in.gov/medicaid/partners. A copy of the *MCE Enrollment Form* is found in *Appendix G*. The MCEs must submit the form to the fiscal agent's Care Programs director. The form includes the following:

- MCE name
- Address
- Contact name
- Telephone number
- Electronic funds transfer (EFT) information
- MCE contact information

If this information changes after enrollment, the MCE must complete the *MCE Enrollment Update Form* and submit it to the fiscal agent.

When the required information is verified, the fiscal agent enrolls the MCE in *Core*MMIS and sends confirmation letters to the FSSA and the MCE. MCEs are enrolled statewide, and the confirmation letters contain the MCE's unique 10-digit identification number (9999999999). The 10th digit denotes the region of the state in which the MCE is enrolled.

HIP has one statewide region designation in *Core*MMIS. The HIP region identifier is H.

8.2 Managed Care Entity Provider Network Requirements

The MCE must ensure that its provider network:

- Is supported by written provider agreements
- Is available and geographically accessible, and
- Provides adequate numbers of facilities, physicians, ancillary providers, service locations, and personnel for the provision of high-quality covered services for its members, in accordance with *42 CFR 438.206*

The MCE must also ensure that all its contracted providers are IHCP providers and can respond to the cultural, racial, and linguistic needs of its member populations. The network must be able to handle the unique needs of its members, particularly those with special healthcare needs. The MCE is required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner.

In some cases, members may receive out-of-network services. To receive reimbursement from the MCE, out-of-network providers must be IHCP providers. The MCE must encourage out-of-network providers, particularly emergency services providers, as well as providers based in non-traditional urgent healthcare settings such as retail clinics, to enroll in the IHCP. An out-of-network provider must be enrolled in the IHCP to receive payment from the MCE.

8.3 Network Development

The state requires the MCE to develop and maintain a comprehensive network to provide services to its HIP members. The network must include providers serving special needs populations.

The MCE must develop a comprehensive network before the effective date of the contract. The MCE shall establish written agreements with all network providers. The MCE is required to have an open network and accept any IHCP provider acting within their scope of practice until the MCE demonstrates that it meets the access requirements. The state reserves the right to delay initial member enrollment in the MCE's plan if the MCE fails to demonstrate a complete and comprehensive network.

With approval from the state, MCEs 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. The MCE must provide 90 calendar days advance notice to the state of changes to the network that may affect access, availability, and network composition. The FSSA regularly and routinely monitors network access, availability, and adequacy. The state may impose the remedies set forth in Exhibits 3 and 4 to the contract, or require the MCE to maintain an open network, if the MCE fails to meet the following network composition requirements:

- The anticipated enrollment
- The expected utilization of services, taking into consideration the characteristics and healthcare needs of the MCE's HIP members
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services
- The numbers of network providers that 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

The state will assess liquidated damages and impose other authorized remedies, such as requiring the MCE to maintain an open network, for MCEs' noncompliance with the requirements for network development and composition.

The MCE must contract with its specialist and ancillary provider network before receiving enrollments. The state reserves the right to implement corrective actions and assesses liquidated damages, as described in Exhibits 3 and 4 of the contract, if the MCE fails to meet and maintain the specialist and ancillary provider network access standards. The state's corrective actions may include, but are not limited to, withholding or suspending new member enrollment from the MCE until the MCE's specialist and ancillary provider network is in place. The state monitors the MCE's specialist and ancillary provider network to confirm the MCE is maintaining the required level of access to specialty care. The state reserves the right to increase the number or types of required specialty providers at any time.

8.4 Network Composition Requirements

In compliance with *42 CFR 438.207*, the MCE must:

- 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.

At the beginning of its contract with the state, the MCE must submit regular network access reports, as directed by the state. After the MCE demonstrates compliance with the state's access standards, the MCE must submit network access reports annually and any time the provider network changes substantially (such as the MCE no longer meets the network access standards). The State reserves the right to expand or revise the network requirements, as it deems appropriate. The MCE must not discriminate with respect to participation, reimbursement, or indemnification as to any provider that 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, as stated in *42 CFR 438.12*. If the MCE declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This requirement does not require the MCE to contract with providers beyond the number necessary to serve the members' needs. The MCE is not precluded from establishing any measure designed to maintain quality and control costs consistent with the MCE's responsibilities.

As required under *42 CFR 438.206*, the MCE must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members, if the MCE also serves commercial members. The MCE must also make covered services available 24 hours a day, seven days a week, when medically necessary. In meeting these requirements, the MCE must:

- Establish mechanisms to ensure compliance by providers.
- Monitor providers regularly to determine compliance.
- Take corrective action if there is a failure to comply
- Provide the state written notice at least 90 calendar days in advance of the MCE's inability to maintain a sufficient network in any county.

For purposes of the following subsections, "urban areas" are counties not designated by the FSSA and approved by the CMS as rural counties. "Rural areas" are those areas designated by the FSSA and approved by the CMS as rural counties.

8.4.1 Residency Programs

To promote long-term relationships for managed care members, physicians practicing in group residency programs are not eligible to enroll as PMPs in the HIP program. The frequent turnover of physicians in a residency program disrupts the continuity of care essential to a managed care program. Residents can provide care to HIP members only if the residency program's faculty physicians are participating PMPs and are enrolled in *Core*MMIS in the same billing group as the resident physicians. The PMP or faculty physician retains responsibility for the care provided to patients and must provide oversight to the resident physician consistent with the residency program's stated procedures.

8.4.2 Acute Care Hospital Facilities

The MCE must 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 residence shall be the usual and customary, not to exceed 30 miles in urban areas and 60 miles in rural areas. Exceptions must 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.

8.4.3 Primary Medical Provider Requirements

Providers may contract as a Primary Medical Provider (PMP) with one or multiple MCEs. A PMP may also participate as a specialist with another MCE. The PMP may maintain a patient base of non-HIP members (such as commercial, traditional Medicaid, Hoosier Healthwise, or Hoosier Care Connect members). An MCE may not prevent the PMP from contracting with other MCEs.

The MCE must 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 healthcare and make any necessary referrals.

The state requires the MCE to provide access to PMPs within at least 30 miles of the member's residence. Providers who may serve as PMPs include the following:

- Internal medicine physicians
- General practitioners
- Family medicine physicians
- Obstetricians/Gynecologists
- General internists
- General pediatricians
- Endocrinologists (if primarily engaged in internal medicine)
- Advance practice registered nurses
- Physician assistants

The MCE's PMP contract must state the PMP panel size limits, and the MCE must assess the PMP's non-HIP practice when assessing the PMP's capacity to serve the MCEs members. The fiscal agent maintains a separate panel for PMPs contracted with more than one MCE. The state monitors the MCE's PMP network to evaluate its member-to-PMP ratio. The MCE must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services 24 hours a day, seven 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 24 hours a day, seven days a week.

Each PMP must be available to see members at least three days per week for a minimum of 20 hours per week. The MCE must also assess the PMP's non-HIP practice to ensure that the PMP's HIP population is receiving accessible services on an equal basis with the PMP's non-HIP population.

An important state goal is to ensure members have quality access to their PMPs. In the past, a restriction limited PMP enrollment to no more than two locations. This was managed via a system limitation on the Portal which limited PMP enrollments to two service locations although the PMP could be contracted with all three MCEs. As PMPs use network extenders more often and in more locations, the state understands service locations may now be broadened without sacrificing quality service and access. In response, the state removed the Portal restriction to two service locations per MCE. The state continues to expect that access, quality, and clinical outcomes are monitored to substantiate this.

This does not reduce the plans' responsibility for provider enrollment but will increase each plan's ability to independently manage its network up to the contract limit.

The MCE must ensure that the PMP provides *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 MCE must ensure that members have telephone access to their PMP (or appropriate designate, such as a covering physician) in English and Spanish 24 hours a day, 7 days a week.

The MCE must ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the applicable *Provider Reference* modules, according to practice type. The MCE must monitor medical care standards to evaluate access to care and quality of services provided to members, and to evaluate providers regarding their practice patterns.

8.4.3.1 Full-Panel Add Requests

When an MCE receives a full-panel add request for a member who is not on its 834 file, the MCE must deny the request. The denial must be sent with a message indicating that the full-panel add submitted cannot be processed because the MCE does not have this member on file. If the member is enrolled in another MCE or showing traditional Medicaid, the member must be instructed to contact the enrollment broker to pursue additional education and information on how to change MCEs, if applicable. If the member is eligible to change MCEs, the PMP may pursue sending the full-panel add with the MCE at that time. The MCEs must have a procedure in place for processing the full-panel add after the member joins the MCE via the 834 file.

The state nor the enrollment broker accepts or processes any paperwork from the PMP or the MCEs requesting a member be added to a full panel. The enrollment broker handles calls from members requesting a plan change if the member qualifies for one. If the member does not, the request is handled via the normal *just cause* change process, with a referral back to the MCE. Additionally, when a PMP changes MCEs, members are allowed to follow their PMP if they choose. The enrollment broker accepts and processes a member's request to change MCEs because of the member's PMP change. This change is allowed regardless of whether the member is now in an open enrollment status, and there is no referral back to the MCE. The enrollment broker confirms that the PMP did change plans before allowing the change. There is a just cause reason code (PMP changed plans) for these type changes, which applies to HIP members.

The MCEs are responsible for letting the PMP know that the full-panel add request cannot be processed, because the member is not connected to that MCE. The enrollment broker no longer has that responsibility.

8.4.4 Physician Extenders

Physician extenders are healthcare professionals who are licensed to practice medicine under the supervision of a physician. Physician extenders can perform some of the services that physicians provide, such as physical exams, preventive healthcare, and education. Some can also assist in surgery and write prescriptions.

Appropriate use of physician extenders can have a positive influence on cost, quality, and access. Physician extenders can perform routine or straightforward services at a lower cost than a physician, allowing physicians to focus on more complicated patient problems. Physician extenders also allow patients to be seen promptly for preventive visits or less complicated health problems, which improves access to care and may allow more Medicaid patients to be seen.

The following physician extenders are licensed to provide care in the state:

- Advanced practice nurses, including nurse practitioners, nurse midwives, and clinical nurse specialists
- Physician assistants, and

- Certified registered nurse anesthetists

The MCE shall implement initiatives to encourage providers to use physician extenders. Examples of these types of initiatives include, but are not limited to:

- Educate providers about reimbursement policies for physician extenders.
- Offer financial or nonfinancial incentives to providers who increase their use of physician extenders. Any financial incentives must be positive, not punitive.
- Collaborate with physician-extender training programs in Indiana. Collaboration could include providing internships or practicum for physician extenders, expanding the number of training slots for physician extenders, and so forth.

State Medicaid programs are required to make nurse practitioner services available to Medicaid recipients in accordance with *42 CFR 441.22*. Members are allowed to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the MCE's network. If nurse practitioner services are available through the MCE, the MCE must inform the member that nurse practitioner services are available.

8.4.5 Federally Qualified Health Centers and Rural Health Clinics

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are essential safety net providers. The state strongly encourages each MCE to contract with FQHCs and RHCs that are willing to meet all the MCE's requirements to provide quality services. The MCE must reimburse FQHCs and RHCs for services at no less than the level and amount of payment that the MCE would make to a non-FQHC or non-RHC provider for the same services.

MCEs must make covered services provided by FQHCs and RHCs available to HIP member's out-of-network if an FQHC or an RHC is not available in the member's service area within the MCE's network. In accordance with *Section 5006(d)* of the *American Recovery and Reinvestment Act of 2009* (ARRA), the MCE shall pay any out-of-network American Indian/Alaska Native healthcare provider that is an FQHC for covered services provided to an American Indian/Alaska Native member at a rate equal to the amount of payment that the MCE would pay to an in-network FQHC that is not an American Indian/Alaska Native healthcare provider for the same services.

In accordance with the Medicare, Medicaid, and *SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)*, the state makes supplemental payments to FQHCs and RHCs that subcontract (directly or indirectly) with the MCE. 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 MCE.

Effective July 2021, FQHCs and RHCs providers should bill the MCE for one unit of code T1015 on the claim. If a claim is submitted with more than one unit, reimbursement of the "wrap" payment will be delayed because only one unit is allowed per member, per day, per diagnosis code. The T1015 line is for information only. MCEs **must** pay the T1015 claim line at $0 and not deny that claim line. If the claim line for T1015 is denied, then the wrap payment is not generated. Providers should be educated that they should not bill an amount on the T code line, but either way the MCE should pay this line at zero regardless of the amount so the state can pay the wrap payment.

The state requires the MCE to identify, and obtain the state approval of, any performance incentives it offers to the FQHC or RHC. The MCE must report all FQHC and RHC incentives that accrue during the contract period related to the cost of providing FQHC-covered or RHC-covered services to its members. This reporting must also include any fee-for-service and capitation payments in determining the direct reimbursement paid by the MCE to the FQHC or RHC. In its reporting to the state, the MCE must specify whether the incentives vary between its Hoosier Healthwise and HIP lines of business.

The MCE must perform quarterly claim reconciliation with each contracted FQHC or RHC to identify and resolve any billing issues that may have an impact on the clinic's annual reconciliation conducted by the state.

Annually, the state requires the MCE to provide the MCE's utilization and reimbursement data for each FQHC and RHC in each month of the reporting period. A separate report must be provided for the MCE's HIP line of business. The report must be completed in the form and manner set forth in the *MCE Reporting Manual*. The data must be submitted on a paid-claims basis.

The submitted FQHC and RHC data must be accurate and complete. The MCE must pull the data by NPI or Provider ID, rather than other means, such as a federal tax identification number (TIN). The MCE must establish a process for validating the completeness and accuracy of the data, and a description of this process must be available to the state on request. The claims files must not omit claims for practitioners rendering services at the clinic, and the files must not contain claims for practitioners who did not practice at the clinic.

In addition, the state requires the FQHC or RHC and the MCE to maintain and submit records documenting the number and types of valid encounters provided to members each month. Capitated FQHCs and RHCs must also submit encounter data (such as in the form of shadow claims to the MCE) each month. The number of encounters is subject to audit by the state or its representatives.

The MCE must work with each FQHC and RHC to assist the state and its designee in resolving disputes of year-end reconciliations between the federally required interim payments made by the state to each FQHC and RHC on the basis of provider-reported encounter activity and the final accounting, based on the actual encounter data provided by the MCE.

8.4.6 Specialist and Ancillary Provider Network Requirements

In addition to maintaining a network of PMPs, the MCE must provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers.

As with PMPs, specialist and ancillary providers are not limited to serve in only one MCE network. In addition, physicians contracted as a PMP with one MCE may contract as a specialist with other MCEs.

The MCE must ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the applicable *Provider Reference modules*, according to practice type. The state requires the MCE 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.

The state requires the MCE to develop and maintain the following comprehensive network of specialty providers. For providers identified with an asterisk (*), the MCE must provide, at a minimum, two specialty providers within 60 miles of the member's residence. For providers identified with two asterisks (**), the MCE must provide, at a minimum, one specialty provider within 90 miles of the member's residence.

Table 25 – Network Specialty Providers

Specialties	Ancillary Providers
• Anesthesiologists* • Cardiologists* • Cardiothoracic surgeons** • Dentists/Oral Surgeons** • Dermatologists** • Endocrinologists*	• Diagnostic testing* • Durable Medical Equipment providers • Home Health • Prosthetic suppliers**

Specialties	Ancillary Providers
• Gastroenterologists* • General surgeons* • Hematologists • Infectious disease specialists** • Interventional radiologists** • Nephrologists* • Neurologists* • Neurosurgeons** • Nonhospital-based anesthesiologist (such as pain medicine)** • OB/GYNs* • Occupational therapists* • Oncologists* • Ophthalmologists* • Optometrists* • Orthodontists* • Orthopedic surgeons* • Orthopedists • Otolaryngologists • Pathologists** • Physical therapists* • Psychiatrists* • Pulmonologists* • Radiation oncologists** • Rheumatologists** • Speech therapists* • Urologists*	

The state requires that the MCE maintain different network access standards for the listed ancillary providers as follows:

- Two (2) durable medical equipment providers must be available to provide services to the MCE's members in each county or contiguous county.
- Two (2) home health providers must be available to provide services to the MCE's members in each county or contiguous county.

In addition, the MCE must demonstrate the availability of providers with training, expertise, and experience in providing tobacco dependence treatment, especially to pregnant women. Evidence that providers are trained to provide tobacco dependence treatment must be available during the state's monthly on-site visits.

The MCE must contract with the Indiana Hemophilia and Thrombosis Center or a similar state-approved, federally recognized treatment center. This requirement is based on 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 fewer bleeding episodes, and experience a 40% reduction in morbidity and mortality.

The MCE must arrange for laboratory services only through IHCP-enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

8.4.7 Pharmacies

MCEs must establish a network of pharmacies. The MCE or its pharmacy benefit manager (PBM) must provide at least two pharmacy providers within 30 miles or 30 minutes from a member's residence in each county, as well as at least two durable medical equipment providers in each county or contiguous county.

8.4.8 Non-Psychiatrist, Non-SUD Behavioral Health Providers

MCEs must establish a network that includes psychiatrists and other behavioral health providers, addressing mental health and addiction. The MCE is required to contract with all Division of Mental Health and Addiction (DMHA)-certified community mental health centers (CMHCs). If all CMHCs are not included in the provider network, the MCE must demonstrate that this does not prevent coordination of care with MRO and 1915(i) State Plan services. Further, the MCE must, at a minimum, establish referral agreements and liaisons with contracted and noncontracted CMHCs, and must provide physical health and other medical information to the appropriate CMHC for every member.

The DMHA conducts regular annual Consumer Service Reviews to evaluate the quality of care provided in the CMHCs. In addition to the regular oversight that the MCE provides for contracted CMHCs, the MCEs must use the results of the DMHA's review to inform contracting decisions, to monitor contracted CMHCs, and to develop improvement plans with contracted CMHCs.

The MCE must meet the following network composition requirements for non-psychiatrist behavioral health providers:

- In urban areas, the MCE must provide at least one behavioral health provider within 30 minutes or 30 miles from the member's residence.
- In rural areas, the MCE must provide at least one behavioral health provider within 45 minutes or 45 miles from the member's residence. The availability of professionals will vary, but access problems may be especially acute in rural areas. The MCE must provide assertive outreach to members in rural areas where behavioral health services may be less available than in more urban areas.

The MCE also must monitor utilization in rural and urban areas to ensure equality of service access and availability. The following list represents behavioral health providers that must be available in the MCE's network:

- 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)(3)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Licensed marital and family therapists
- Licensed mental health counselors

All services covered under the clinic option 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.

8.4.9 Inpatient Psychiatric Facilities

The MCE must 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 residence must be the usual and customary distance, not to exceed 60 miles. Exceptions must be justified and documented to the state on the basis of community standards for accessing care.

8.4.10 Dental Providers

The MCE shall ensure the availability of a dentist practicing in general or family dentistry within 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 60 miles of the member's residence.

8.4.11 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.

8.4.12 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 say 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.

8.4.13 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.

8.4.13.1 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.

8.4.13.2 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.

8.4.13.3 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.

8.4.13.4 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.

8.4.13.5 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, 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), ARRA 5006(a), and 42 CFR 447.51(a)(2).

- 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.

8.4.13.6 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.

8.4.14 County Health Departments

OMPP strongly encourages the MCE to contract or enter into business agreements with any health departments that are willing to coordinate with the MCE and are able to meet the MCE's credentialing and service delivery requirements.

8.4.15 Urgent Care Clinics

The MCE must affiliate or contract with urgent care clinics. Urgent care clinics must be made available no less than 11 hours each day, Monday through Friday, and no less than five hours each day on the weekend.

In addition, the state strongly encourages the MCE to affiliate or contract with nontraditional urgent care clinics, including retail clinics. The state will continue to monitor the MCE's access to primary and urgent care.

8.4.16 Dialysis Treatment Center

The Contractor shall ensure the availability of one dialysis treatment center within sixty (60) miles of the member's residence.

8.4.17 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 Contract Section 2.10.

8.4.18 Non-emergency Medical Transportation Providers

In accordance with 42 CFR 440.170 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.

8.5 Provider Enrollment

The MCE components of HIP are subprograms of the IHCP in *Core*MMIS. As such, participating providers must be IHCP-enrolled. The MCE is responsible for ensuring that all its providers are IHCP-enrolled at the service location where they wish to participate as a PMP. The MCE is also responsible for ensuring that there are sufficient providers to adequately serve enrolled members.

Provider enrollment activities are governed by the following criteria:

- MCE provider outreach personnel assume responsibility for education of providers enrolled in the MCE. State-contracted provider personnel from the enrollment broker or the fiscal agent can also provide general information about the HIP program.
- After enrolled in the IHCP, PMPs contract with the MCEs. PMPs are allowed to enroll with multiple MCEs and maintain member enrollment in each MCE and program.
- PMPs determine the maximum panel limits of HIP members for each MCE. The state monitors each MCE's PMP network to evaluate its member-to-PMP ratio on at least a quarterly basis.
- If a PMP disenrolls from HIP, or disenrolls as an IHCP provider entirely, MCEs must ensure that members continue to receive care for a minimum of thirty (30) calendar days or until another PMP is chosen or assigned.
- When a PMP disenrolls from the HIP program, the MCE is responsible for assisting the members assigned to that PMP in selecting a new PMP within the MCE's network. If the member does not select another PMP within a reasonable amount of time, the MCE must assign the member to another PMP in the MCE's network before the original PMP disenrollment is effective.
- The MCE must make a good faith effort to provide written notice of a provider's disenrollment to any member who has received primary care services from that provider or otherwise sees the provider on a regular basis. Notice must be provided within 15 calendar days of the MCE's receipt or issuance of the provider's termination notice.

8.5.1 Indiana Health Coverage Programs Provider Enrollment Processing

To participate as a PMP or specialist in the HIP Program, a provider must be enrolled as an IHCP provider. A provider is enrolled in the IHCP when all the following conditions have been met:

- The provider is duly licensed, registered, or certified by the appropriate professional regulatory agency pursuant to state or federal law, or otherwise authorized by the FSSA.
- The provider has completed, signed, and returned an IHCP Provider Agreement and any other forms required by the IHCP.
- The provider has been assigned a provider identification number.
- Physicians must be actively enrolled at the service location where they wish to practice as a PMP before enrolling as a PMP at that location.

The IHCP provider enrollment procedures are designed to ensure timely, accurate, and efficient processing of provider enrollment applications. This procedural base is the focus of provider participation and is critical for accurate claims processing. It is the MCE's responsibility to ensure that any network providers delivering services to members in the HIP program are enrolled as IHCP providers. Providers enroll initially by completing the *Indiana Health Coverage Programs Provider Agreement* and mailing it to:

IHCP Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

Detailed information about compiling the provider enrollment application and agreement is found in the *IHCP Provider Enrollment Module* provider reference module on the Provider References page at in.gov/medicaid/providers. Providers may also contact the fiscal agent's Provider Enrollment by telephone at 800-457-4584 to request enrollment applications and to get answers to questions about IHCP provider enrollment.

8.5.2 IHCP Electronic Provider Files

IHCP provider extract files are posted to the IHCP file exchange for the MCEs' use. Provider files list all actively enrolled IHCP providers in *Core*MMIS, regardless of PMP status.

MCEs use this information to pay out-of-network providers for carved-out and any other services rendered to their members in and out of network. Files include address and service locations, provider NPI crosswalk data and revalidation information.

The list of IHCP provider extract files and their frequencies can be found in Appendix H. The file layouts are posted to the *MCE Secure Landing* page at in.gov/medicaid/partners.

8.5.3 Managed Care Entity Primary Medical Provider Enrollments and Updates

MCEs can submit individual PMP enrollments for their HIP plan through the Portal. MCEs can also update the existing PMP's scope of practice, network, panel-hold status, and panel-size information. Panel size and network updates require effective dates that are the day after data entry or a future date. Updates to the panel size are viewable the day after data entry or when the change becomes effective. Updates to the panel-hold and scope-of-practice information are processed the day the update is completed in PMP Update using the Portal. Panel hold and full status are used for information purposes in *Core*MMIS and are viewable in the *Portal > Provider Profile*.

Providers may access the Portal from the IHCP website. All MCEs must enroll in the Portal as group administrators and establish user IDs and passwords to access the Portal. MCE group administrators can assign users and enable them with appropriate access to the Portal.

When users log on to the Portal, they must click the *Provider Profile* link. Then they have the option to view the provider profile, enroll a PMP, update PMP information, view a list of the fiscal agent's provider field consultants, and download the PMP enrollment, update, and other program enrollment forms. Only users who are assigned access to the PMP Enrollment Membership task see the *Enroll a PMP, Update PMP,* or the *PMP Enrollment and Update Forms* section on the provider profile menu. Users also can access help text to assist them with PMP enrollments and updates. The MCE must log in as the MCE ID of the program where they intend to enroll the PMP so that *Core*MMIS can differentiate between the two programs when establishing the PMP service location.

MCEs must complete the selection process by entering the IHCP group or billing ID, selecting a service location and, if a group provider, selecting the applicable rendering provider. After the selection process is finished, the MCE must enter the 24-hour telephone number, scope-of-practice information, panel size, and network information, if applicable. After the MCE's data entry is complete and has passed the system cross-editing, the MCE must click *Submit*. A confirmation web page appears, stating that the PMP enrollment has been successfully processed. The window also includes the submission date, enrollment date, MCE name, provider ID number, group number, and alpha service location ID. MCEs can print the confirmation web page for PMP enrollment tracking purposes.

The following sections outline the paper enrollment process that can be used if system issues prevent web PMP enrollment.

8.5.4 Linking Primary Medical Providers to Managed Care Entity Networks

All MCEs have the capability to establish PMP networks for the HIP program and enroll their PMPs accordingly in the Portal. MCEs also have the ability to disenroll their PMPs from networks using the Portal.

To create an MCE network, the MCE completes the *Healthy Indiana Plan (HIP) MCE Network Enrollment Addendum.*

This form is accessible from the *MCE Secure Landing* page at in.gov/medicaid/partners. Completed forms are submitted to the fiscal agent Managed Care Unit. MCEs specify the network's name, effective dates, and four-digit ID. After the fiscal agent enters the networks under the applicable MCE and region in *Core*MMIS, MCEs can see the networks that are available in the region for the PMP service location being enrolled in the lower portion of the enrollment window. The following PMP-network functions are available:

- Link an existing PMP service location to a network.
- Link a PMP service location to a network as part of the initial enrollment.
- End-date a network affiliation for a PMP service location.

PMP-network effective and end-dates must be greater than or equal to the processing date. The PMP's network name, when applicable for the date of service, appears in eligibility verification responses after the MCE name and telephone number.

8.5.5 Paper File Submission

MCEs are encouraged to use the Portal for submitting enrollments. If the MCE is unable to access the web, they may submit forms to the state fiscal agent at the following address or fax them to the attention of

Managed Care enrollment at (317) 488-5020. MCEs must use this option only when the Portal access is not available for more than 24 hours Monday – Friday, or because of other extenuating circumstances agreed to by the fiscal agent and the state. The form for enrolling a PMP in the MCE may be found in the **Portal** > **Provider Enrollment**.

IHCP Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

The following procedure for manual enrollment submissions readily identifies submissions as belonging to an MCE and confirms to MCEs that the enrollments have been processed:

1. The PMP enrollment requests must be sent with a cover letter containing the MCE's name, the signature of the MCE provider representative, MCE fax number, and an itemized list of the enrollment forms submitted. The itemization must include fields for the following information:
   - PMP name
   - Provider identification number
   - Effective date
2. The MCE must complete the PMP name and provider identification number.
3. On receipt of the MCE's PMP enrollment forms, the PMP enrollment coordinator enters the data into *Core*MMIS, verifying the following information:
   - Valid IHCP numbers
   - IHCP eligibility
   - Valid PMP provider type and specialty
   - Valid IHCP service location
   - Valid group and individual relationships
   - Number of PMP service locations
   - Acceptable panel size
4. The PMP enrollment coordinator annotates the MCE cover letter to indicate the effective date or the reason the enrollment could not be processed.
5. The PMP enrollment coordinator confirms the disposition of the enrollments by sending an email confirmation to the submitter.

Because PMP enrollment in the MCE is a manual process, no exception reports are generated.

8.5.6 Changes to Primary Medical Provider Scope of Practice

PMPs may request changes to their scope-of-practice information by contacting their affiliated MCEs. The scope of information includes the following:

- Admit Privileges – Options: Relationship or Privileges
- Delivery Privileges – Options: Yes or No
- Age Restrictions – Options: None, 0-2 years of age, 0-12 years of age, 0-17 years of age, 0-20 years of age, 13-17 years of age, 13-20 years of age, 21 years of age and older, 3 years of age and older, 17 years of age and older, 13 years of age and older
- 24-Hour Telephone Number and Extension
- Accept Obstetrics – Options: Yes or No
- Accepts All Women – Options: Yes or No

- Panel Size
- Panel Size Hold
- Panel Size Hold Removal
- Gender – Options: Male, Female, Male/Female

Scope-of-practice information listed previously is specific to the Hoosier Healthwise program. HIP leverages the Hoosier Healthwise scope of practice forms even though some of the PMP provider types and age ranges may not be a match for HIP members.

On receipt of a change request from a PMP, the MCE can perform a change through the *Portal > Provider Enrollment > Update Your Provider Profil*e.

8.6 Provider Disenrollment

A PMP can be disenrolled from the HIP program for various reasons. MCEs are responsible for reassigning members assigned to PMPs disenrolling from their plan. MCEs must have a policy and procedure in place to identify these members and ensure that they are enrolled in a new PMP in a timely manner. MCEs are required to end-date disenrolling HIP PMP service locations in *Core*MMIS, so this information is available for reporting and available for the enrollment broker.

MCEs disenroll their own PMP service locations using the Portal. Access is similar to the procedure used by the MCEs to enroll PMP service locations. MCEs must enroll in the Portal as group administrators and establish user IDs and passwords to access the Portal. MCE group administrators can assign users and enable them with appropriate access.

8.6.1 Steps for Disenrolling a Primary Medical Provider

1. Disenroll online using the Provider Healthcare Portal OR
2. Complete the *IHCP Provider Disenrollment Form*.
3. Detailed instructions are included in the form.
4. Be sure to get appropriate signatures.
5. The disenrollment form is an interactive PDF file, allowing you to type information into the fields from your computer, save the completed file to your computer, and print the file for mailing.
6. Make a copy of the form for your records.
7. Mail the form to the following address:

IHCP Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

8.6.2 IHCP Disenrollment and Primary Medical Provider Disenrollment

Immediate PMP terminations (such as a PMP's death) that are the result of IHCP terminations are carried out by the fiscal agent's Provider Enrollment Unit. The fiscal agent's Provider Enrollment Unit notifies the MCE when one of the MCE's PMPs has been disenrolled. PMPs terminated by the fiscal agent are disenrolled using the reason code, *IHCP termed*.

With the exception of an emergency event, such as the PMP's death, the fiscal agent's Provider Enrollment Unit notifies the MCE that the MCE has five business days to disenroll the PMP through the Portal. If the PMP is not disenrolled after 5 days, the Provider Enrollment Unit disenrolls the PMP and notifies the PMP's MCE. MCEs use the PMP disenrollment reason codes available to them through the Portal disenrollment process (reason codes listed previously in step 5).

The Provider Enrollment Unit team members have the ability to retroactively end-date a PMP's eligibility with an MCE, with the approval of the fiscal agent's Care Program Unit. An example of a retroactive end date is a PMP's date of death when received by Provider Enrollment Unit one week after the PMP actually died.

8.7 Provider Agreements

The MCE must have a process in place to review and authorize all network provider contracts. The MCE must submit a model or sample contract of each type of provider agreement to state for review and approval at least 60 calendar days before the MCE's intended use. The MCE must notify the state of any changes to the sample contracts.

The MCE must include in all its provider agreements provisions to ensure continuation of benefits. The MCE must identify and incorporate the applicable terms of its contract with the state and any incorporated documents, including the RFS. Under the terms of the provider services agreement, the provider must agree that the applicable terms and conditions set out in the *Healthy Indiana Plan Scope of Work*, 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 that subcontracts indemnify and hold harmless the state of Indiana do not extend to the contractual obligations and agreements between the MCE and healthcare providers or other ancillary medical providers that have contracted with the MCE.

In addition to the applicable requirements for subcontracts in *Section 5.4* of the *Healthy Indiana Plan Scope of Work* in the MCE's contract with the state, the provider agreements must meet the following requirements:

- 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 MCE's members within 90 calendar days or fewer from the date of service. The MCE must waive the timely filing requirement in the case of claims for members with retroactive coverage, such as pregnant women.
- Require each provider to use the *Indiana Health Coverage Program Prior Authorization Request Form*, available at in.gov/medicaid/providers, for submission of prior authorization requests to the MCE.
- Include a termination clause stipulating that the MCE must terminate its contractual relationship with the provider as soon as the MCE has knowledge that the provider's license or IHCP provider agreement has terminated.
- Terminate the provider's agreement to serve the MCE'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 the state's or the MCE's standards.
- Obligate the terminating provider to submit all encounter claims for services rendered to the MCE's members while serving as the MCE's network provider and provide or reference the MCE'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 MCE. Said advance notice must not have to be more than 90 calendar days.
- Provide a copy of a member's medical record at no charge on 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 must 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 before 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 MCE must 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 noncontracted providers outlined in *405 IAC 1-1.6-1*.

8.8 Provider Credentialing and Recredentialing Policies and Procedures

The MCE must have written credentialing and recredentialing 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 MCE's credentialing and recredentialing process for all contracted providers must meet the *National Committee for Quality Assurance (NCQA)* guidelines. The same provider credentialing standards must apply across Hoosier Healthwise and HIP programs.

The MCE must use the *IHCP MCE Practitioner Enrollment form* and the *IHCP MCE Hospital/Ancillary Enrollment form* or gather the information identified on the forms during the credentialing process. The *IHCP Practitioner Enrollment Form* and the *IHCP Hospital/Ancillary Enrollment Form* can be found on the *IHCP Provider Enrollment Transactions* page at in.gov/medicaid/providers. The MCE must ensure that providers agree to meet all the state's and the MCE's standards for credentialing PMPs and specialists, and maintain IHCP manual standards, including:

- Compliance with state recordkeeping requirements
- The state's access and availability standards
- Other quality improvement program standards

As provided in *42 CFR 438.214(c)*, the MCE's provider credentialing and selection policies must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCE must not employ or contract with providers that have been excluded from participating in federal healthcare programs under Section 1128 or Section 1128A of the *Social Security Act*. The MCE must notify the state of any credentialing applications that are denied because of program integrity-related issues.

8.8.1 Credentialing

The MCE must have written policies and procedures for credentialing healthcare professionals it employs and with whom it contracts. The MCE must have documented plans to periodically review and revise policies and procedures. If the MCE contracts with a hospital that conducts the MCE's credentialing

activity, the MCE must have access to the hospital's credentialing files. At minimum, the MCE must obtain and verify the following:

- A current valid license to practice
- Status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility
- Current and valid Drug Enforcement Administration (DEA) or controlled-substance registration (CSR) certificate, as applicable (DEA certificates are not applicable to chiropractic settings)
- Proof of graduation from medical school and completion of a residency, or board certification for doctors of medicine (MDs) and doctors of osteopathy (DOs), as applicable, since the last time the provider was credentialed or recredentialed
- Proof of graduation from a chiropractic college for doctors of chiropractic medicine (DC)
- Proof of graduation from podiatry school and completion of residency program for doctors of podiatric medicine (DPMs)
- Work history that includes a minimum of five years on the curriculum vitae (the MCE is not required to verify work histories)
- Current, adequate malpractice insurance, according to the MCE's policies
- History detailing any pending professional liability claims and claims resulting in settlements or judgments paid by or on behalf of the practitioner
- Proof of board certification, if the practitioner states he or she is board certified
- Verification of IHCP enrollment
- For a group enrollment, verify that the provider is linked appropriately to the group, and that the provider is enrolled at the appropriate service locations
- Verification that the provider, or an agent or managing employee of the provider, is not debarred, suspended, or otherwise excluded by federal agencies or from participating in any contract paid with federal funds

The credentialing policies and procedures must specify the professional criteria required to participate in the MCE. Each practitioner's file must contain sufficient documentation to demonstrate that these criteria are evaluated. Primary sources used by the MCE to verify credentialing information must be included in its policies and can include using external agencies, such as county medical societies, hospital associations, or private verification services.

The MCE shall process all credentialing applications within 30 calendar days of receipt of a complete application. If the MCE delegates credentialing functions to a delegated credentialing agency, the MCE shall ensure that all credentialed providers are loaded into the MCE's provider files and claims system within 15 calendar days of receipt from the delegated entity.

8.8.2 Mechanisms for Credentialing and Recredentialing

The MCE must document the mechanism for credentialing and recredentialing MDs, DOs, DPMs, and DCs that fall under the MCE's scope of authority and action, and with whom it contracts or employs to treat members outside the inpatient setting. This documentation includes, but is not limited to, the following:

- Scope of practitioners covered
- Criteria and the primary source verification of information used to meet these criteria
- Process used to make decisions
- Extent of any delegated credentialing or recredentialing arrangements

Policies and procedures must specify the requirements and processes used to evaluate practitioners. Selection decisions must be based on the network needs of the MCE and on practitioners' qualifications. Selection decisions cannot be based solely on a practitioner's membership in another organization, such as a hospital or medical group.

Policies and procedures must include specific details regarding the physicians and other licensed independent practitioners who are subject to these policies, and criteria to reach a decision.

The MCE must have a process in place for receiving advice from participating practitioners in credentialing and recredentialing to ensure that procedures are followed consistently. MCEs must seek practitioner expertise on current practice in the medical community and advice on modifying the criteria, as appropriate. This expertise can be obtained from a committee with participating practitioner representation or from consultation with participating practitioners.

Participating practitioners must complete applications for membership on such a committee. Through the application process, the practitioner discloses information about health status and history of issues with licensure or privileges that may require additional follow-up. A signed attestation statement on the application ensures that the practitioner has completed it in good faith.

Before making a credentialing decision, the MCE must have the following information about the practitioner:

- Information from the National Practitioner Data Bank (NPDB). NPDB is not applicable to chiropractors and podiatrists
- Information about sanctions or limitations on licensure from the state Board of Medical Examiners, Federation of State Medical Boards, or the Department of Professional Regulations, if available
- Information from the state Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards
- Information from the state Board of Podiatric Examiners
- Previous sanction activity by Medicare and the IHCP

Evidence indicating that the MCE has obtained information from the previously designated organizations must be included in the credentialing file.

8.8.3 Credentialing – Initial Visit

NCQA no longer requires initial provider credentialing visits for certain provider types. However, the state continues to require that the MCE credentialing process includes an initial visit to the offices of all potential primary medical providers (PMPs), including all obstetricians and gynecologists (OB/GYNs). There must be a structured review that evaluates the site against the MCE standards. The initial site visit must also document evaluation of the medical recordkeeping practices at each site to ensure conformity with the maintenance of medical records. See *Member Services* for additional information.

8.8.4 Recredentialing

The MCE must have a formal recredentialing process that verifies credentialing information subject to change over time. The recredentialing process must be organized to verify the information through a primary source on the current standing of items listed in this section, such as member complaints, quality reviews, utilization management, and member satisfaction. The description of the recredentialing process must include data from at least three of the following six sources:

- Member complaints
- Quality reviews (practice-specific)

- Utilization management (profile of utilization)
- Member satisfaction (practice-specific)
- Medical record review
- Practice site reviews

The recredentialing process must use this data as objective evidence when reappraising professional performance, judgment, and clinical competence. There must be evidence that the MCE has taken action based on the data. Examples of action taken include continuation in the MCE, required supervision or participation in continuing education, evidence that the MCE has drawn up a clear plan for the practitioner's improvement, evidence of changes in the scope of practice, or termination of the practitioner from the MCE.

8.8.5 Recredentialing Practice Site Visit

The MCE must conduct an on-site visit at the time of recredentialing to determine if there have been changes in the facility, equipment, staffing, or medical recordkeeping practices that would affect the quality of care or services provided to members of the MCE. Primary medical providers, OB/GYNs, and other high-volume specialists must be included in this site visit. The MCE is responsible for determining which high-volume specialists are subject to this visit, based on its own experience with the specialist.

8.8.6 Altering Conditions of Provider Participation

MCEs must have plans for developing and implementing policies and procedures for altering conditions of a provider's participation with the MCE because of quality of care and service issues. These policies and procedures need to specify actions the MCE may take before terminating the provider's participation with the MCE. Policies and procedures must have mechanisms in place for reporting serious quality deficiencies to the state that could result in a provider's suspension or termination. These policies and procedures must specify how reporting occurs and the individual staff members responsible for reporting deficiencies.

The policies and procedures must include a well-defined appeals process for instances in which the MCE decides to alter the provider's condition of participation because of quality of care or service issues. The MCE must ensure that providers are aware of the appeals process. Policies and procedures must include mechanisms to ensure that providers are treated fairly and uniformly.

8.8.7 Credentialing Provider Healthcare Delivery Organizations

The MCE must have policies and procedures for credentialing healthcare delivery organizations, including, but not limited to, hospitals, home health agencies, freestanding surgical centers, laboratories, and subcontracted networks of providers.

Every three years after the initial contract, the MCE must confirm the following:

- The organizations are in good standing with state and federal regulatory bodies.
- The organizations have been reviewed and approved by an accreditation body before contracting with the MCE.
- The organizations conform to the previously mentioned requirements.

The MCE must also develop standards of participation and assess these providers accordingly if the provider has not received accreditation.

8.8.8 Clinical Laboratory Improvement Amendments

MCEs must arrange for laboratory services only through laboratories with current CLIA certificates.

8.9 Maintenance of Medical Records

The MCE must ensure that its participating providers maintain medical and other records of all medical services provided to enrollees by the MCE and its providers for seven years, in accordance with *Indiana Code* (*IC) 16-39-7-1*. The MCE medical records standards must be consistent, to the extent feasible, with NCQA accreditation standards for medical records. The records must at least be legible and must include the following:

- Patient identification information (patient name or identification number) on each written page or electronic file record
- Personal biographical data
- Entry date
- Date on which the service was rendered
- Provider identification, and if applicable, the identity and position of the provider's employee rendering the service
- Diagnosis of the medical condition of the individual to whom service was rendered, and a detailed statement describing services rendered
- The location at which services were rendered
- Written evidence of physician involvement and personal patient evaluation to document acute medical needs
- Allergies
- Past medical history
- Immunizations
- Medical information
- Consultations
- Referrals
- Medical conditions and health maintenance concerns
- Written instructions for living wills or durable power of attorney for healthcare when the patient is incapacitated and has such a document
- A record of outpatient and emergency care
- Specialist referrals
- Ancillary care
- Diagnostic tests and findings
- Prescriptions for medications
- Inpatient discharge summaries
- Histories and physicals, including a list of smoking and chemical dependencies
- EPSDT services
- A current plan of treatment and progress notes as to the necessity and effectiveness of treatment must be attached to the prior authorization request and available for audit purposes.

Providers must maintain 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 adequate system for follow-up treatment. Health records must be legible, signed, dated, and maintained for at least seven years, as required by *IC 16-39-7-1*. Confidentiality of protected health information (PHI) must be maintained, in accordance with 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 state (or MCE) must have access to medical records for medical record reviews. In accordance with *Indiana Administrative Code (IAC) 405 IAC 1-5-1*, the PMP must retain all records relating to the provision of MCE services for at least seven years from the date of record creation. The PMP must transfer, at the request of the state or the MCE, a summary or copy of a member's medical records to another PMP if the member is reassigned.

Any physician receiving payments from the IHCP for rendered services may not charge an IHCP member for medical record copying or transfers. Federal regulation *42 CFR 447.15* states that providers participating in Medicaid must accept the state's reimbursement as payment in full (except that providers may charge for deductibles, coinsurance, and copayments).

8.10 Provider Education and Outreach Activities

The MCE must provide ongoing education to its provider network on the HIP program, as well as MCE-specific policies and procedures. In addition to developing its own provider education and outreach materials, the MCE shall be required to coordinate with the FSSA-sponsored provider outreach activities on request. The MCE must educate its contracted providers, including behavioral health providers, about provider requirements and responsibilities, the MCE's prior authorization policies and procedures, clinical protocols*member's rights and responsibilities, claim submission processes, claim dispute-resolution processes, pay-for-performance programs, and any other information relevant to improving services.

**If the MCE chooses to produce clinical practice guidelines (CPG) as education for providers on specific medical topics, they must limit those CPGs to a maximum of four every two years. These CPG are distinct from medical policy and utilization management (UM) criteria that inform UM decisions.*

The MCE must provide education and outreach about the different HIP benefit plans, including the separate PDL for the *HIP State Plan* and the formulary for *HIP Plus* and *HIP Basic* benefits; medically frail policies and procedures; state Personal Wellness and Responsibility (POWER) Accounts, including preventive care and roll over; copayments for emergency department services; and copayments for *HIP Basic* and *HIP State Plan Basic* services.

The MCE must also educate its HIP providers about its pregnancy-related services and policies. Such education must emphasize that women are able to receive a full range of maternity services in any HIP category and do not have to wait until they are transitioned to *HIP Maternity.*

Provider education must also include information about member cost-sharing, including the 5% cap on cost-sharing and the requirement that providers reduce or waive member copayments if notified by the MCE or the state that the member's family has exceeded the 5% cap on member cost-sharing. Any notification to providers shall identify the time period during which the copayments must be reduced or waived.

All provider communications must be preapproved by the state. The MCE must submit all provider communications (that is, promotional, training, educational, and outreach materials) to the state for review and approval at least 30 calendar days before using and distributing the information. The MCE must also submit any material changes to previously approved provider communications to the FSSA for review and approval at least 30 calendar days before use and distribution. The MCE must develop and include an MCE-designated inventory control number on all provider materials with a *date issued* or *date revised*

clearly marked to facilitate the state's review and approval process. With the state's approval, the MCE may distribute provider materials to the provider community.

All state-approved provider communications must be available on the MCE's provider website within three business days of distribution. The provider communication materials must be organized online in a user-friendly, searchable format by communication type and subject.

8.10.1 Provider Policies and Procedures Manual

The MCE will develop and maintain a *Provider Policies and Procedures Manual* for use by the MCE's network of HIP providers. The *Provider Policies and Procedures Manual* must be available both electronically and in hard copy (on request) to all network providers, without cost, when providers are initially enrolled; when there are any changes in policies and procedures; and upon a provider's request. The *Provider Policies and Procedures Manual* must include, at minimum, the following information, separately stated for the Hoosier Healthwise and HIP lines of business, as appropriate:

- Benefits and limitations of coverage
- 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 their patient
- Provider nondiscrimination 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 and 42 CFR 438.400-424 and 42 CFR 438.10(g)(2)(xi)(A)-(E)
- Policies and procedures for grievances and appeals, in accordance with *42 CFR 438.414*
- Frequently asked questions and answers
- MCE and the FSSA contact information, such as addresses and telephone numbers

The MCE must offer *Provider Policies and Procedures Manual* training to all network providers when they are initially enrolled in the network, whenever policies or procedures change, 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 the FSSA for review and approval.

8.10.2 Pre-Enrollment Provider Education

The MCEs can educate physicians interested in becoming PMPs about the HIP program through face-to-face training sessions, brochures, and videos. The state must pre-approve all education and outreach materials designed for distribution to physicians interested in becoming PMPs.

Before enrolling PMPs in the MCE program, MCEs are encouraged to educate providers about the following:

- HIP program goals
- Member PMP selection and the PMP change process within their plans and programs
- Practice requirements of a PMP include 24-hour access standards

- Provider disenrollment
- Preventive health standards and requirements
- Referral standards (for example, referrals for continuity of care)
- Quality improvement requirements (including EPSDT)
- Self-referral services
- Billing and reimbursement practices
- Covered and excluded services and referral practices for HIP
- Other relevant MCE-specific information

> ***Note:*** *All prospective PMPs must first be enrolled in the IHCP at the service location at which they want to be enrolled as PMPs. MCEs must verify IHCP enrollment with prospective PMPs before enrolling them using the Portal. If the prospective PMP is not IHCP-enrolled, the MCE must tell the physician to contact the fiscal agent for an enrollment application, or the physician (or physician's group) can download the appropriate application at in.gov/medicaid/providers.*

8.10.3 Post-Enrollment Provider Education

As part of the enrollment process for health plan PMPs, the MCE must educate PMPs about the following:

- How PMPs are notified about panels – MCEs provide member enrollment roster information to their contracted network PMPs.
- Universally accepted standards of preventive and other care – These standards are determined by the MCE. MCEs are strongly encouraged to employ the Practice Standards. Practice standards are updated as needed.
- Medical records retention and availability – This information is described in *Maintenance of Medical Records*.
- PMP authorization requirements – This information is described in *Authorization of Services and Notice of Actions*.
- HIP benefit plans, including information about the specific covered services and exclusions of each, as well as the recommended preventive care guidelines for HIP members.
- HIP POWER Accounts and cards
- *HIP Basic* and *HIP State Plan Basic* copayment requirements
- Provider claims dispute – These procedures are developed by the MCE. Minimum requirements are described in *Provider Dispute Procedures*.
- Provider helpline – MCEs must offer a toll-free telephone helpline to providers. The MCE must report provider help-line performance statistics, as described in the *MCE Reporting Manual*. The MCE help-line staff must be prepared to respond to provider concerns including, but not limited to, the following:
  - Enrollment and disenrollment from the MCE
  - Provider grievances and claim disputes
  - Covered services
  - Self-referral services
  - Provider network development as described in this section
  - Quality improvement requirements as described in *Quality Improvement and Utilization Management*
  - Billing requirements

  - Eligibility issues
  - Preventive health standards and requirements (including EPSDT)
  - Encounter data requirements as described in *Information Systems*
- Reassignment of a member to another PMP – This process, as initiated by the provider, is described in *Member Enrollment*.

8.10.4 HIP-Specific Provider Education

For its HIP providers, the MCE must provide education and outreach about the different HIP benefit plans, including the separate Preferred Drug List (PDL) for the *HIP State Plan* and the formulary for *HIP Plus* and *HIP Basic* benefits; medically frail policies and procedures; POWER Accounts, including preventive care and rollover; copayments for emergency department services; and copayments for *HIP Basic* and *HIP State Plan Basic* services.

The MCE must also educate its HIP providers about its pregnancy-related services and policies. Such education must emphasize that women are able to receive a full range of maternity services in any HIP category and do not have to wait until they are transitioned to *HIP Maternity (MAMA) benefit plan*.

Provider education must also include information about member cost-sharing, including the 5% cap on cost-sharing and the requirement that providers reduce or waive member copayments if notified by the MCE or the state that the member's family has exceeded the 5% cap on member cost-sharing. Any notification to providers shall identify the time period during which the copayments must be reduced or waived.

8.10.5 Provider Newsletters

The MCE must distribute provider bulletins or newsletters, at least four times per year, that provide updates related to provider services and policies and procedures specific to the HIP program.

8.11 Managed Care Entity Communications with Providers

The MCE must establish policies and procedures to maintain frequent communications and provide information to its provider network. As required by the *Code of Federal Regulations (CFR) 42 CFR 438.207(c)*, the MCE must notify the state of material changes that may affect a procedure at least 30 calendar days before notifying its provider network of the changes. The MCE must give providers at least 45 calendar days' advance notice (per *IC 12-15-13-6*) of material changes that may affect the providers' procedures. The MCE must post a notice of the changes on its website to inform both network and out-of-network providers, and must make payment policies available to noncontracted providers on request.

Because some pharmacy services are covered by Indiana Medicaid FFS under the pharmacy benefit consolidation, MCEs must educate providers about which pharmacy services should be submitted to the state fiscal agent for reimbursement, and which should be submitted to the MCE. The MCE must also ensure that providers receive education about the different PDLs applicable to the various HIP benefit plans, and that they have readily available information regarding a member's applicable PDL.

In accordance with *42 CFR 438.102*, the MCE must not prohibit or otherwise restrict a healthcare professional from acting within the lawful scope of practice, including advising or advocating on behalf of a member.

8.11.1 Provider Website

The MCE must develop and maintain a user-friendly website for network and out-of-network providers within six (6) months of the effective date of the MCE's contract with the state. The state must pre-approve the information and graphic presentations on the MCE's website. The MCE may choose to develop a separate provider website or incorporate it into the home page of the member website.

To minimize download and wait times, the website must 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 MCE must date each web page, change the date with each revision, and enable users to print the information.

The provider website may have secured information available to network providers but must, at a minimum, have the following information available to all providers:

- MCE's contact information.
- MCE provider policy and procedure manual and necessary forms.
- MCE bulletins or newsletters issued not fewer than four times a year that provide updates related to provider services, and updated policies and procedures specific to the HIP population.
- All provider communication materials, organized online in a user-friendly, searchable format by communication type and topic
- Claim submission information – For example, but not limited to, MCE submission and processing requirements, paper and electronic submission procedures, emergency department auto-pay lists, and frequently asked questions.
- Claims dispute resolution procedures for contracted and out-of-network providers.
- Prior authorization procedures, including a complete list of services that require prior authorization
- Appeal procedures
- Entire network provider listings
- Links to the state's website for general IHCP and HIP information
- Information about the MCE's chronic disease management program
- HIPAA and *42 CFR Part 2* privacy policy and procedures
- Network participation request information including all of the information, steps and forms that are required from the provider for a request to join the network and be credentialed

8.11.2 Provider Services Helpline

The MCE must maintain a toll-free telephone helpline for all providers with questions, concerns, or complaints. The MCE must staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a 12-hour business day, Monday through Friday, from 8 a.m. to 8 p.m., except for the following holidays during which the provider helpline may be closed:

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

The MCE may request that additional days, such as the day after Thanksgiving, be authorized for limited staff attendance. This request shall be submitted to the state at least thirty (30) calendar days in advance of the date being requested for limited staff attendance and must be approved by the state. 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 MCE must maintain a system for tracking and reporting the number and type of providers' calls and inquiries. The MCE must monitor its provider helpline and report its telephone service performance to the state, as described in the *MCE Reporting Manual.*

8.11.3 IHCP Workshops and Seminars

The fiscal agent sponsors quarterly workshops throughout the state and an annual seminar for all IHCP providers. The MCE must participate in the annual provider seminar and in quarterly regional workshops in its service areas.

During the workshops, the MCE must have appropriate representatives available to make formal presentations and respond to questions during scheduled times. The state also encourages MCEs to set up information booths with representatives available during the annual seminar.

8.11.4 Provider Welcome Letter

The MCEs must 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 MCE may add additional language at the discretion of and approval by OMPP.

MCEs are required to send out the provider welcome letter, either by mail or email, within five (5) business days of the network participation process completion. The completion date for the network participation process is defined as all components of the network participation process being completed including:

- enrolling the provider
- credentialing the provider, if applicable
- contracting with or executing an amendment to add the provider
- provider is loaded into all systems and can submit claims for services rendered
- provider has been added to the provider directory, if applicable

The welcome letter may not state that there are further steps in the network participation process. The welcome letter should be the final confirmation that the provider is fully enrolled in the MCE network and able to render services.

The MCEs must modify the welcome letter language if they will use the first of the month following the contract execution as the effective date for brand new providers.

8.11.4.1 Standard Welcome Letter Language

Welcome to the <MCE> provider network. Please review all this information carefully.

Your effective date with our network is: MM/DD/YYYY. You are now fully enrolled and may render services to members. <MCE may add specific program or network name as applicable.>

Your effective date was assigned following the Indiana Medicaid network effective date policy. The effective date policy is as follows and can be found on our website.

- Providers will be effective with an MCE first of the month following the receipt of a complete network participation request.

- The effective date will be no sooner than the IHCP effective date.
- A brand-new provider that is not part of an existing contract with the MCE will be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date the MCE receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
- A provider that is being added to an existing contract will also be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date the MCE receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
- To be able to render services, the contract or contract amendment must still be executed by both parties.

We encourage you to visit our website at <enter MCE website> for resource materials and regular updates. In particular,

- Provider Manual
- Provider Portal
- Claims Submission Information and Instructions
- Forms
- Clinical Practice Guidelines
- Member Rights and Responsibilities
- Health and Wellness Materials

If you need to contact us for any reason, <MCE enter steps for how providers can contact someone to help answer questions>.

8.12 Member Financial Responsibility

8.12.1 Copayments and Cost-Sharing

All HIP members (with the exception of members exempt from cost-sharing) are required to pay monthly contributions towards their POWER Account or copayments for services received. Specific cost-sharing requirements vary by plan type.

8.12.1.1 *HIP Plus* Cost-Sharing

To participate in *HIP Plus* or *HIP State Plan Plus*, individuals are required to help fund the $2,500 deductible by contributing to their POWER Account on a monthly basis. Required contributions are tiered based upon member's household income and FPL level. For married couples participating in *HIP Plus*, the state will divide the monthly contribution between the two HIP-eligible married adults, and each member is responsible for half of the tiered amount on a monthly basis. Regardless, in no event will a member's monthly POWER Account contribution be less than $1. The state will determine the individual's required monthly POWER Account contribution and will notify the MCE of this amount.

8.12.1.2 *HIP Basic* 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 copayments at the time services are rendered. Copayments

are collected based on one charge per type of service, per provider, per date of service, and they include the following:

- No copayment is required for preventative care, maternity services, or family planning services.
- $4 copayment for outpatient services
- $75 copayment for inpatient services
- $4 copayment for preferred drugs
- $8 copayment for non-preferred drugs
- $8 copayment for non-emergent ED use

8.12.1.3 *HIP State Plan* Member Cost-Sharing

Members receiving *HIP State Plan* benefits must either pay POWER Account contributions in an amount equivalent to *HIP Plus* members if the member is enrolled in *HIP State Plan Plus,* or copayments for services in an amount equivalent to *HIP Basic* members if the member is enrolled in *HIP State Plan Basic*.

8.12.1.4 Cost-Sharing Exempt Populations

Pursuant to federal law, the MCE may not collect POWER Account contributions or impose any other cost-sharing, including copayments for non-urgent use of hospital emergency departments, on members who are pregnant, members who have reached their 5% cost sharing requirement, or members identified as an American Indian/Alaska Native (AI/AN) pursuant to *42 CFR 136.12*. The state will identify all AI/AN members through the eligibility determination process.

8.12.2 Charging Members for Services Rendered

In limited instances, a provider can charge IHCP members for services. Services not covered by the IHCP, such as cosmetic procedures can be billed to the member if the provider receives and retains the member's signed statement accepting financial responsibility for the services. This statement must be specific about the services to be billed, must be signed by the member before services are rendered, and must be retained as documentation in the patient's medical record. See the Charging Members for Noncovered Services section of the *Provider Enrollment* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers.

A provider may bill a HIP member if the provider has taken appropriate action to identify a responsible payer, and the member failed to inform the provider of their eligibility before the timely filing limitation.

8.12.3 Member's Maximum Total Annual Aggregate Cost-Sharing

Total member cost-sharing will not exceed 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 5% of the FPL are required to contribute, at a minimum, monthly $1 POWER Account contributions. The MCE will work with the state to consider all contributions made by the household in the calculation and monitoring of the 5% contribution limit.

As used in this section, *total aggregate cost-sharing* means POWER Account payments, HIP copayments, ED copayments, Medicaid copayments, member debt collected by the MCE during the quarter, and/or other cost-sharing information available to the MCE. Any service not specifically listed as a covered benefit in the applicable HIP alternative benefit plan may not be applied against the member's 5% contribution calculation. For purposes of this section, the household income includes the income considered in *407 IAC 2-2-2*.

The MCE and member are responsible for monitoring their total aggregate cost-sharing for the benefit period to ensure that it has not reached 5% of the family's income. It is recommended that the member maintain all documentation to substantiate the amount of cost-sharing paid by the family. When a family's total cost-sharing expenditures come close to exceeding 5% of the family's income in the quarterly period, the MCE shall be required to notify the state. The MCE shall also coordinate with the state to notify providers and the family that additional cost-sharing during the period is reduced or waived.

When the MCE identifies a member or a member notifies their MCE with satisfactory documentation that substantiates that their total aggregate cost-sharing has reached 5% of their income for the benefit quarter:

- The MCE will notify the state that the member has reached their cost-sharing maximum for the benefit quarter.
- The state will notify the MCE via the 834 benefit transaction of the member's new $0 cost-sharing for the remainder of the benefit quarter.
- The members are not required to make copayments. The members will still be responsible for $1.00 PAC, even if they have already met the 5% cost-share.
- The MCE refunds any ED copayments paid during the remainder of the benefit quarter.
- Members with income below $27 will have their cost-share obligation turned off from the start of their eligibility.

8.12.4 Annual and Lifetime Benefit Caps

HIP has no annual or lifetime benefit caps.

8.13 Provider Service Locations

MCEs must verify that the physician is IHCP-enrolled before submitting a PMP enrollment via the Portal. PMPs participating with an MCE can have service locations in any Indiana county that the MCE's state contract allows. Physicians can download the *IHCP application* at https://www.in.gov/medicaid/

8.13.1 Out-of-State Providers

To enhance access to primary care in areas with an inadequate number of PMPs, the State permits out-of-state PMPs to enroll in the program in areas where limited access has been identified. Concurrent with the implementation of the program statewide effective July 1996, the State developed criteria to determine which areas would most benefit from additional PMPs with out-of-state locations, permitting these enrollments on a case-by-case basis according to predetermined access measures. PMPs with out-of-state service locations are available for voluntary selection by members.

Effective July 1, 2019, the IHCP expanded the out-of-state areas that it designates as "in-state" for PA requirements, to include counties located within the metropolitan statistical areas (MSAs) of major cities within or bordering Indiana. Providers with service locations in the out-of-state counties are as follows:

- Chicago-Naperville-Elgin area
  - Cook county
  - DeKalb county
  - DuPage county
  - Grundy county
  - Kane county
  - Kendall county
  - Lake county

  - McHenry county
  - Will county
- Cincinnati area
  - Boone county
  - Bracken county
  - Brown county
  - Butler county
  - Campbell county
  - Clermont county
  - Gallatin county
  - Grant county
  - Hamilton county
  - Kenton county
  - Pendleton county
  - Warren county
- Louisville/Jefferson county area
  - Bullitt county
  - Henry county
  - Jefferson county
  - Oldham county
  - Shelby county
  - Spencer county
  - Trimble county
- Evansville area
  - Henderson (Kentucky)
- South Bend-Mishawaka area
  - Cass (Michigan)

8.14 Hospital Assessment Fee

The hospital assessment fee (HAF) program is designed to increase hospital inpatient and outpatient reimbursement to eligible hospitals to align with the federal Medicare program level of payment. The HAF is assessed against all in-state acute care hospitals licensed under *Indiana Code (IC) 16-21-2* and freestanding psychiatric hospitals licensed under *IC 12-25*. The state also maintains a share of the HAF to cover costs related to the Medicaid program.

MCEs are responsible for maintaining their own list of HAF-eligible facilities. They should also be aware that HAF adjustment factors may be modified as necessary to reasonably approximate the Medicare upper-payment limits without exceeding them.

HAF-eligible hospitals are paid by MCEs using diagnosis-related group (DRG) or level-of-care (LOC) methodology, as appropriate, with the HAF adjustment factors applied.

All non-HAF-eligible hospitals continue to be reimbursed at their current rates and methodologies for inpatient and outpatient services rendered to all HIP members. Covered services are reimbursed at the Medicare reimbursement rate, or if there is not a Medicare reimbursement rate, at 130% of the Medicaid rate.

Additional information can be found in the *Hospital Assessment Fee* provider reference module on the Provider Reference Materials page at in.gov/medicaid/providers.

8.14.1 Inpatient HAF Application Process

HAF applies only to claims billed on a UB-04 institutional claim form or electronically through the 837I transaction, or through the MCE's Provider Portal. Physician and professional services are excluded.HAF adjustment factors for previous years can be found in these IHCP Bulletins: BT202389 (in.gov), BT202261 (in.gov), BR202129 (in.gov), BT202079 (in.gov). The inpatient HAF adjustment factors for claims with dates of service on or after August 1, 2023, are as follows:

Table 26 – Inpatient HAF Adjustment Factors

Reimbursement Rate	HAF Adjustment Factor
Inpatient DRG Base Rate	3.5
Inpatient Rehabilitation LOC Rate	3.2
Inpatient Burn LOC Rate	1.0
Inpatient Psychiatric LOC Rate	3.2

8.14.2 Outpatient HAF Application Process

The outpatient HAF adjustment factor for claims, excluding those for clinical laboratory services provided in an outpatient setting, is as follows effective August 1, 2023:

Table 27 – Outpatient HAF Adjustment Factor

Reimbursement Rate	HAF Adjustment Factor
Outpatient Rate*	3.9

*Excludes clinical laboratory services provided in an outpatient setting.

HAF adjustment factors for previous years can be found in these IHCP Bulletins: BT202389 (in.gov), BT202261 (in.gov), BR202129 (in.gov), BT202079 (in.gov).

HAF applies to the following outpatient bill types:

- How to code bill type: If '110'<=bill_type<='129' then patient='INP' and if '130'<=bill_type<='149' or '850'<=bill_type<='859' then patient='OUT'.

8.14.3 Individual Claim HAF Eligibility

1. Using the Indiana Hospital Association (IHA) report, determine claims and their HAF criteria eligibility (provides all the provider Medicaid IDs).
    i. Usually, there is only one National Provider Identifier (NPI) associated with each Medicaid ID, though it is possible to have multiple IDs.
    ii. If there are multiple IDs, split the dollars out at the NPI level, not at the Medicaid ID level.
2. Filter down the claims that are serviced in the time period specified. Typically, the dates of July 1 through June 30 are used.

i. For inpatient stays, use the admission date, not the date of service, to ensure that the entire claim is kept together.

ii. Remove any claims paid after the paid-date cut-off (often referred to as run-out). Traditionally, the paid-date cut-off is June 30 of the next year to allow a full year of run-out.

In the report, the costs should be categorized as inpatient and outpatient costs using the bill type of the claim. Bill type was chosen because every facility claim should have one, and it is an industry standard.

If the bill type is in the range:

- 110 – 129: costs fall under inpatient
- 130 – 149 or 850 – 859: costs fall under outpatient

The claims should be summarized at the NPI level, and the report should contain the following fields:

- Indiana Medicaid Provider ID
- Provider Medicare ID
- NPI
- Provider address (provider's city, state, and ZIP Code [ZIP+4 if available])
- Total paid inpatient claims
- Total paid outpatient claims

The claim detail used to build the report should be kept in case the state has further questions about the submission.

Tables 28 and 29 can be used to identify an inpatient or outpatient claim that would be eligible for HAF.

Table 28– Inpatient Claims Eligible for HAF

Inpatient Claim		
1st Digit Bill Type	**2nd Digit Bill Type**	**3rd Digit Bill Type**
1 – Hospital	1 – Inpatient (Medicare Part A)	0 – Nonpayment or Zero Claims
1 – Hospital	1 – Inpatient (Medicare Part A)	1 – Admit Through Discharge Claim
1 – Hospital	1 – Inpatient (Medicare Part A)	2 – Interim (First Claim)
1 – Hospital	1 – Inpatient (Medicare Part A)	3 – Interim (Continuing Claims)
1 – Hospital	1 – Inpatient (Medicare Part A)	4 – Interim (Last Claim)
1 – Hospital	1 – Inpatient (Medicare Part A)	5 – Late Charge Only
1 – Hospital	1 – Inpatient (Medicare Part A)	7 – Replacement of Prior Claim or Corrected Claim
1 – Hospital	1 – Inpatient (Medicare Part A)	8 – Void or Cancel of a Prior Claim
1 – Hospital	1 – Inpatient (Medicare Part A)	9 – Final Claim for a Home Health PPS Episode
1 – Hospital	2 – Inpatient (Medicare Part B)	0 – Nonpayment or Zero Claims
1 – Hospital	2 – Inpatient (Medicare Part B)	1 – Admit Through Discharge Claim
1 – Hospital	2 – Inpatient (Medicare Part B)	2 – Interim (First Claim)
1 – Hospital	2 – Inpatient (Medicare Part B)	3 – Interim (Continuing Claims)
1 – Hospital	2 – Inpatient (Medicare Part B)	4 – Interim (Last Claim)
1 – Hospital	2 – Inpatient (Medicare Part B)	5 – Late Charge Only
1 – Hospital	2 – Inpatient (Medicare Part B)	7 – Replacement of Prior Claim or Corrected Claim
1 – Hospital	2 – Inpatient (Medicare Part B)	8 – Void or Cancel of a Prior Claim
1 – Hospital	2 – Inpatient (Medicare Part B)	9 – Final Claim for a Home Health PPS Episode

Table 29– Outpatient Claims Eligible for HAF

Outpatient Claim		
1st Digit Bill Type	**2nd Digit Bill Type**	**3rd Digit Bill Type**
1 – Hospital	3 – Outpatient	0 – Nonpayment or Zero Claims
1 – Hospital	3 – Outpatient	1 – Admit Through Discharge Claim
1 – Hospital	3 – Outpatient	2 – Interim (First Claim)
1 – Hospital	3 – Outpatient	3 – Interim (Continuing Claims)
1 – Hospital	3 – Outpatient	4 – Interim (Last Claim)
1 – Hospital	3 – Outpatient	5 – Late Charge Only
1 – Hospital	3 – Outpatient	7 – Replacement of Prior Claim or Corrected Claim
1 – Hospital	3 – Outpatient	8 – Void or Cancel of a Prior Claim
1 – Hospital	3 – Outpatient	9 – Final Claim for a Home Health PPS Episode
1 – Hospital	4 – Other (Medicare Part B)	0 – Nonpayment or Zero Claims
1 – Hospital	4 – Other (Medicare Part B)	1 – Admit Through Discharge Claim
1 – Hospital	4 – Other (Medicare Part B)	2 – Interim (First Claim)
1 – Hospital	4 – Other (Medicare Part B)	3 – Interim (Continuing Claims)
1 – Hospital	4 – Other (Medicare Part B)	4 – Interim (Last Claim)
1 – Hospital	4 – Other (Medicare Part B)	5 – Late Charge Only
1 – Hospital	4 – Other (Medicare Part B)	7 – Replacement of Prior Claim or Corrected Claim
1 – Hospital	4 – Other (Medicare Part B)	8 – Void or Cancel of a Prior Claim
1 – Hospital	4 – Other (Medicare Part B)	9 – Final Claim for a Home Health PPS Episode
8 – Specialty Facility, Hospital ASC Surgery	5 – Comprehensive Outpatient Rehabilitation Facility (CORF)	0 – Nonpayment or Zero Claims
8 – Specialty Facility, Hospital ASC Surgery	5 – Comprehensive Outpatient Rehabilitation Facility (CORF)	1 – Admit Through Discharge Claim
8 – Specialty Facility, Hospital ASC Surgery	5 – Comprehensive Outpatient Rehabilitation Facility (CORF)	2 – Interim (First Claim)
8 – Specialty Facility, Hospital ASC Surgery	5 – Comprehensive Outpatient Rehabilitation Facility (CORF)	3 – Interim (Continuing Claims)
8 – Specialty Facility, Hospital ASC Surgery	5 – Comprehensive Outpatient Rehabilitation Facility (CORF)	4 – Interim (Last Claim)
8 – Specialty Facility, Hospital ASC Surgery	5 – Comprehensive Outpatient Rehabilitation Facility (CORF)	5 – Late Charge Only
8 – Specialty Facility, Hospital ASC Surgery	5 – Comprehensive Outpatient Rehabilitation Facility (CORF)	7 – Replacement of Prior Claim or Corrected Claim
8 – Specialty Facility, Hospital ASC Surgery	5 – Comprehensive Outpatient Rehabilitation Facility (CORF)	8 – Void or Cancel of a Prior Claim

Outpatient Claim		
1st Digit Bill Type	**2nd Digit Bill Type**	**3rd Digit Bill Type**
8 – Specialty Facility, Hospital ASC Surgery	5 – Comprehensive Outpatient Rehabilitation Facility (CORF)	9 – Final Claim for a Home Health PPS Episode

8.15 Provider Network Participation Requests

8.15.1 Network Participation Process

A network participation request is when the provider makes a formal request to enter into a new agreement/contract with the MCE. This includes the mechanism utilized by the MCE to receive the request from the provider or group to join the MCE's network as a contracted provider. The network participation request must include at a minimum the information/fields outlined on the IHCP MCE Practitioner and IHCP MCE Hospital/Ancillary Provider Enrollment and Credentialing Forms and any supporting documentation required from providers for the MCE to enroll, credential and initiate contracting with the provider. MCEs may not require a signed contract in order for a network participation request to be considered complete as it's only the information necessary to begin processing the request.

The MCE must display on their public facing website and other written materials a clearly defined, step-by-step process for how providers submit a network participation request. The information and steps need to include all the information that is required from the provider and any differences by provider type. The information should clearly define for providers what would be considered a complete network participation request. The MCEs may visualize the network participation request using a workflow document, but this is not required.

Providers need to understand the different processes within network participation and understand the unique processes conducted within each of the processes (i.e., enrollment, credentialing, and contracting). OMPP definitions for each of the processes that should be displayed on the MCE website and utilized by the MCEs are below:

- Enrollment - The process of loading a contracted and credentialed provider to all MCE internal systems, loading for claims payment, and loading to the provider directory (if applicable).
- Credentialing - The process of reviewing the qualifications and appropriateness of a provider to join the health plan's network. Credentialing requirements and processes will follow NCQA guidelines.
- Contracting/Negotiating – The process of the provider and MCE formally executing an agreement for the provider to deliver medical services that outlines reimbursement rates, scope of services, etc.

The MCEs are welcome to include additional information to describe each process, but the meaning of each term remain consistent with OMPP's definitions.

The network participation process information should also outline for providers how to submit any additional supporting documentation. Multiple methods should be offered to providers for submitting supporting documentation. The supporting documentation may include but is not limited to:

- W-9
- Debarment Form
- Credentialing Attestation/Information
- Proof of Certification

MCEs must notify providers when an incomplete network participation request is received. Notification of an incomplete network participation request will be sent to providers within five (5) business days after

receipt of initial request. An incomplete network participation request is a request that the MCE cannot fully process because there is missing documentation, information needed to write a contract, etc.

MCEs must also include the most common issues providers make during network participation requests on the MCE website. This information will be used as education for providers on what common issues are seen so they avoid making them and ensure their network participation process is most efficient. This information can be posted directly to the MCE website or in a supporting document posted to the website.

MCEs must outline for providers the information necessary, and steps required to be credentialed with the MCE. MCEs must confirm what provider types require credentialing and which do not. This must be communicated with providers via the MCE website and in direct correspondence with providers.

8.15.2 Provider Network Participation Request Forms

As part of the step-by-step instructions provided on the website, the MCE must clearly outline which form(s) need to be completed. This includes whether the MCE Network Participation Request or the IHCP Enrollment Forms should be submitted and the method for submitting.

If an online form is to be utilized by providers to submit the network participation request, the MCE must include an instruction sheet for how to use the online form.

MCE Network Participation Request forms must include all the IHCP MCE Practitioner Enrollment Form and IHCP MCE Hospital/Ancillary Provider Enrollment Form fields to allow for efficient data capture and prevent providers from having to submit multiple network participation request forms. If the MCE utilizes an online form or other MCE generated form, the MCE must include all fields found on the IHCP Enrollment Forms. The MCE Network Participation Request forms must be approved by OMPP Quality and Outcomes unit for approval prior to implementation.

The use of additional network participation request forms to gather information not included on the IHCP Enrollment Forms is permitted so long as the MCE specifies in the step-by-step network participation process exactly which forms are required.

8.15.3 Provider Effective Dates

MCEs must follow the following network effective date policy for all network participation requests. This effective date should be followed for all provider types and for all delegated provider networks. The same effective date policy will be in place regardless of whether the network participation request is for a hospital/ancillary provider or a practitioner. Providers must be fully enrolled and effective as an IHCP provider prior to becoming effective with an MCE.

Providers will be effective with an MCE on the first of the month following the receipt of a complete network participation request and the additional guidance below.

- A brand-new provider that is not part of an existing contract with the MCE will be effective the first of the month following receipt of the network participation request from the provider or following the contract execution. It is at the discretion of the MCE to decide which effective date will be utilized.
    - The network participation receipt date is the date the MCE receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
    - If the MCE uses the contract execution date, the new provider will be effective the first of the month following the contract execution date.
    - The effective date utilized must be followed for all brand-new provider network participation requests.

- A provider that is being added to an existing contract will be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date the MCE receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
- In order to be able to render services, the contract or contract amendment must still be executed by both parties.
- MCEs are encouraged to use the standard out of network process for services rendered by providers prior to the effective date if needed for member access to care.
- The MCE network effective date must also be after the IHCP effective date. Providers must be enrolled and effective with IHCP prior to being effective with an MCE.
- The effective date will be the first of the month following the receipt of a complete network participation request, regardless of the contract execution date or credentialing completion date. In most cases, the effective date will be retroactive back to the first of the month following receipt of the complete network participation request since providers will not be fully effective until they are credentialed by and have a signed contract or contract amendment with the MCE.
    - If a provider is unable to be credentialed with the MCE, the provider will not be effective with the MCE.
    - If a provider and MCE cannot come to terms with a contract, the provider will not be effective with the MCE.
- Providers should hold all claims until the final welcome letter from the MCE is received confirming that they are effective with the MCE network. MCEs and providers are expected to complete all pieces of the network participation process timely. However, in instances where the network participation process extends for a time period longer than the standard timeframe, MCEs will not hold providers to the timely filing limit for claims rendered before the provider was confirmed effective.
- OMPP will allow the MCEs flexibility to deny the provider participation request if the contracting phase cannot be completed in an acceptable timeframe that is no more than 60 days. This will allow the effective date policy to remain consistent but also hold all parties accountable for the turnaround of necessary items for the network participation process. It is important that the MCEs educate providers on the significant impact any delay in signing a contract will have and that if they do not meet the timeframe their request will be denied.

OMPP will provide the MCEs with flexibility to negotiate an appropriate retroactive effective date with a provider in the following situations:

- When the retroactive date is in the best interest of member care.
- In situations involving changes of ownership, including provider mergers, acquisitions, or tax identification changes.
- In situations where a provider has a preexisting contractual relationship with an MCE and has sought a change in their provider enrollment type or classification with the IHCP (i.e., when a provider was enrolled as a Billing provider but has decided to enroll as a Group provider).
- Upon request from providers in federally qualified health centers (FQHCs) or rural health clinics (RHCs).

This effective date policy shall be used for network participation requests received on or after January 1, 2022.

8.15.3.1 Effective Date Communication to Providers

The MCE must outline the network effective date policy in all written policy and procedures.

The MCE must make the network participation effective date policy readily available to all provider types. The policy should be posted to the MCE's public facing website. The MCE must also include the effective

date policy and the specific effective date on the provider welcome letter so that the provider understands how the effective date was calculated.

8.15.4 Provider Network Participation Documentation

8.15.4.1 Central Repository for Network Participation Documentation and Correspondence

The MCE must 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. Written correspondence and email correspondence that occurs with providers and provider groups related to the network participation process should also be stored in the repository.

OMPP always reserves the right to audit the provider network participation process and view all correspondence that has occurred regarding a specific network participation request. The MCE must be able to provide copies of all correspondence during an audit or upon an inquiry request.

The central repository should be used to store all network participation request communications received on or after Jan. 1, 2022.

8.15.2.1 Network Participation Status Updates

The MCE must assign for each network participation request a unique identifier that will confirm receipt of the network participation request and that providers can reference when checking the status of their request. The unique identifier should be provided to the provider at time of the network participation request submission either electronically, via email, or via postal mail. Providers should be able to use this identifier when checking the status of all components of the network participation process, including credentialing, enrollment, and contracting. The MCE may utilize additional internal identifiers if necessary for internal use only.

In the event there is a request for a provider to be added to multiple locations that are tied to the same tax identification number, only one unique identifier may be used for that request. If a provider is requesting to be added to multiple locations that have different tax identification numbers, it is expected that a unique identifier will be used for each location.

The MCE must clearly identify on their website and on any initial network participation request receipt confirmations how providers can check the status of their request. This can include but is not limited to the ability to check the status of a request online, by calling the provider service helpline, or by contacting specific provider specialists at the MCE.

8.15.3 Annual Review of Provider Network Participation Process

The MCE must 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. MCEs should identify if there are frequent issues or questions raised by providers and work to resolve the process to address those. MCEs should also identify if there are manual components of the process that need to be refined.

After issues or key inefficiencies are identified, MCEs should work to implement process improvements to address and correct these inefficiencies.

8.15.3.1 OMPP Annual Compliance Review

OMPP will conduct an annual review of the MCE Provider Network Participation Process to validate compliance with these requirements. The annual review will include auditing all to specific components of the Provider Network Participation Process as well as auditing random provider participation experiences. The MCEs must report on their annual assessment and improvements that were made to address inefficiencies during the OMPP annual compliance review.

The annual compliance review will evaluate the following requirements:

- Network Participation Request Forms
- Network Participation Process
- Network Effective Date Policy
- Provider Notifications
- Repository of Correspondence

The findings from the annual review will be provided in writing to the MCE in a scorecard. The scorecard template is attached. MCEs will receive an Overall Status which will indicate if there are Minor Concerns, Moderate Concerns or Major Concerns. An MCE will be found to be non-compliant if one or more of the requirements have not been met. An MCE will be found to be compliant if all the requirements have been met. The following overall status score will be applied to an MCE based upon the following definitions:

- Minor Concerns - The MCE was compliant with the requirements but has some items that could be improved to continue enhancing the provider experience.
- Moderate Concerns - The MCE was found non-compliant on one of the requirements and improvements must be made.
- Major Concerns - The MCE was found non-compliant on more than one of the requirements, and there are major concerns identified that need to be escalated and resolved immediately; or the MCE was found non-compliant on more than 2 of the requirements and improvements must be made.

MCEs shall engage in process improvements to address any concerns identified and areas of non-compliance.

The timeline for the annual compliance review will be communicated by OMPP.

8.16 Provider Dispute Procedures

The MCE must promptly respond to provider complaints and appeals. The MCE must clearly document and maintain policies and procedures for registering and responding to complaints and must clearly communicate this information to all providers enrolled in the MCE. These policies and procedures must describe in detail the mechanism the MCE uses to track and respond to provider complaints and grievances and provide detailed descriptions of positions responsible for performing each task. These processes must include specific time frames and resources, including but not limited to electronic or manual reports, logs, and any other documentation used to track grievances and complaints. The MCE must also provide the state with detailed descriptions of its written policies and procedures for handling provider grievances. The policies and procedures must follow the requirements set forth in *405 IAC 1-1.6*.

In its quarterly report to the state, the MCE must provide the number of provider grievances, resolved and unresolved, by type and number. Provider grievances must be recorded according to the framework established by the state.

Denial notices to providers must include explanations of specific criteria supporting decisions. If payment for a service is denied, the notice must cite not only the applicable rule provision, but also an explanation of how it fits the particular provision. For example, denials for nonemergency services must restate the definition of emergency services and explain how the specific case fails to meet the criteria.

8.17 Practice Standards

8.17.1 Universally Accepted Practice Standards

There must be evidence that the MCE further enhances quality of service to its HIP members by requiring PMPs to adhere to nationally accepted standards or guidelines for preventive care for pregnant women, infants, children, adolescents, and adults.

The MCE must use or develop preventive health guidelines based on reasonable medical evidence and national guidelines. Guidelines adopted by the MCE must include those endorsed by the following:

- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- American Society of Internal Medicine (ASIM)
- American College of Physicians (ACP)
- American College of Obstetrics and Gynecology (ACOG)
- U.S. Preventive Services Task Force
- American College of Surgeons
- National Cancer Institute (NCI)
- American Cancer Society

The MCE must provide evidence that it reviews the guidelines and scientific literature incorporated into the MCE's preventive health guidelines. Guidelines must be shared with the MCE's Quality Improvement Committee (QIC) and subcommittees, if any, and must include provider participation. The QIC and subcommittees must have opportunities to review, comment, and make modifications reasonable for local practices.

The guidelines must be appropriate for the full spectrum of HIP populations enrolled in the MCE. Primary and secondary prevention must be addressed for populations identified as high risk. Practice guidelines must include areas of study, methodology, indicators, analysis, plans for corrective action, follow-up, and assessment of effectiveness.

The MCE must provide evidence that supports how it shares preventive health guidelines with MCE providers, including new and existing providers. There must also be evidence that the MCE has plans for sharing new and revised guidelines. Communications can include provider newsletters, mailings, and provider reference modules.

The MCE must establish mechanisms to monitor and review provider compliance and consistency in following preventive care guidelines. Barriers must be identified.

MCEs must publicize to members the availability of preventive health services, guidelines for these services, and the recommended frequency or conditions under which prevention activities are required. MCEs may inform members through member newsletters, member orientation packets, member handbooks, and targeted mailings.

> ***Note:*** *Additional evidence-based clinical practice guideline information is available at the National Clinical Guidelines website.*

8.17.2 Prenatal and Pregnancy-Related Care

The state has implemented pregnancy-related standards of care that are applied to members in all Indiana Health Coverage Programs. MCEs must consider these as minimum standards for their HIP enrollees. These standards of care are based on the American Congress of Obstetricians and Gynecologists (ACOG)-recommended policies that include prenatal, delivery, and postpartum care. In general, the IHCP provides coverage for 14 prenatal and two postpartum care visits, which ideally occur throughout a low-risk pregnancy as follows:

- First trimester – Three visits
- Second trimester – Three visits
- Third trimester – Eight visits
- Postpartum – Two visits within eight weeks of delivery

The program does not place limits on the number of prenatal visits reimbursed for members with complicating conditions that designate the member medically high-risk. The IHCP reimburses for appropriate laboratory tests and screenings during the pregnancy and two postpartum visits.

These standards, including diagnoses designated as high-risk and recommended laboratory tests and screenings, are described in the *Obstetrical and Gynecological Services* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers.

Members who enroll with an MCE, either voluntarily or by auto-assignment, in the third trimester of pregnancy must receive particular attention regarding continuity of prenatal care. MCEs must make financial arrangements with out-of-network providers to continue care through pregnancy if members do not wish to change doctors in the late stages of pregnancy.

8.17.3 Future Standards

MCEs are expected to add detailed practice standards for other patient conditions including the following:

- Breast cancer and mammography
- Cervical cancer and pap smears
- Human immunodeficiency virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)
- Asthma
- Diabetes
- Hypertension
- Sexually transmitted diseases
- Cholesterol screening
- Prevention of influenza
- Tobacco dependence treatment
- Immunizations
- Domestic violence

These standards are developed by the state's QIC, based on consultation with and recommendations from the following:

- IHCP physician providers
- Indiana medical community at large

- External Quality Review Organization (EQRO) and the Healthcare Effectiveness Data and Information Set (HEDIS)
- Federal Agency of Health Care Policy and Research (AHCPR)
- Centers for Disease Control and Prevention (CDC)
- IHCP Coordinated Care Technical Assistance Group (TAG)
- Other Department of Health and Human Services (DHHS) collaborative TAG committees

A medical director and one other person knowledgeable about managed care, quality improvement, and data analysis represents MCEs on the QIC committee. MCEs must have practice standards in place for any of the previously listed or other conditions and must make these standards available to HIP enrollees after review and approval by the state.

8.18 Billing and Reimbursement Policies and Procedures

The MCEs and providers in their networks negotiate billing and reimbursement arrangements. These arrangements must support the MCE's general encounter data, utilization, and other reporting requirements described in *Information Systems*.

The MCE must pay providers for covered medically necessary services rendered to the MCE's members in accordance with standards set forth in *IC 12-15-13-1.6* and *IC 12-15-13-1.7*, unless the MCE and provider agree to an alternate payment schedule and method. The MCE must also abide by the specifications of *42 CFR 447.45(d)(5)* and *(d)(6)*, which require the MCE to ensure that the date of receipt is the date the MCE 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 MCE must pay or deny electronically filed clean claims within 21 calendar days of receipt and clean paper claims within 30 calendar days of receipt. If the MCE fails to pay or deny a clean claim within these time frames, but subsequently pays the claim, the MCE must also pay the provider interest, as required under *IC 12-15-13-1.7(d)*. A definition of a *clean claim* is set forth in *IC 12-15-13-0.6*. These standards apply to out-of-network claims for which the MCE is responsible and to any other claims submitted by providers that have not agreed to alternate payment arrangements.

While the MCE may choose to subcontract claims processing functions, or portions of those functions, with a state-approved subcontractor, the MCE must demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral services, and does not result in confusion in the provider community about where to submit claims for payments. For example, the MCE may elect to establish one post office box for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, the MCE must ensure that the subcontracting organizations forward claims to the appropriate processing entity. Use of a method such as this does not lengthen the timeliness standards discussed in this section. In this example, the definition of *date of receipt* is the date of a claim's receipt at the post office box.

8.18.1 Interest Payments to Noncontracted Providers

MCEs are financially responsible for interest payments on clean claims billed by noncontracted providers. The requirement ensures timely payment of claims for services provided to HIP enrollees. Interest is payable in accordance with provisions set forth in *IC 12-15-13*. Claims for services rendered by providers contracted with the MCE are not subject to this provision.

8.18.2 Billing and Balance Billing IHCP Enrollees

IHCP and federal regulations specifically prohibit providers from charging IHCP enrollees for covered services, except in specific, limited circumstances. IHCP-enrolled providers are required to accept the IHCP's determination of payment for covered services as payment in full, except for copayments and any other patient liability payment as authorized by law. The provider must maintain documentation that the member voluntarily chose to receive the service, knowing it was not covered by the program.

The *Provider and Member Utilization* provider reference module on the *Provider Reference Materials* page at in.gov/medicaid/providers contains detailed information about billing IHCP members. Generally, IHCP-enrolled providers can bill members only under the following conditions:

- The service is not covered under the IHCP (for example, cosmetic procedures).
- The member has exceeded the program limitation for a particular service.
- The member understands that the IHCP does not cover the service and accepts financial responsibility before receiving a service that is not covered by the program.
- The services provided are covered or noncovered embellishments or enhancements to covered services. These services can be considered and billed separately from the basic service only if a separate procedure, revenue, or National Drug Code (NDC) exists for the enhancement. Otherwise, a service in its entirety is considered covered or noncovered.
- The provider has taken appropriate action to identify a responsible payer, and the enrollee has failed to inform the provider of IHCP eligibility before the one-year claim-filing limitation.

MCE contracted providers, as IHCP-enrolled, are subject to the same policy outlined previously. While the state and the Centers for Medicare & Medicaid Services (CMS) recognize that there may be circumstances unique to the managed care environment in which billing members may be appropriate, the state discourages this practice. If an MCE elects to permit its contracted providers to bill members under any circumstance, the MCE must do all the following:

- Develop sufficient safeguards to ensure that members are able to access medically necessary services
- Ensure that members are not subject to any coercive practices
- Ensure that members are informed of their right to file grievances

The MCE can permit a provider to bill members for services that require authorization, but for which authorization is denied, if certain safeguards are in place and are followed by the provider. MCEs must establish, communicate, and monitor compliance with procedures that include at least the following:

1. The provider must establish that authorization has been requested and denied before rendering the service.
2. The provider can request MCE review of the authorization decision. The MCE must inform providers of the contact person, the means for contact, the information required to complete the review, and procedures for expedited review, if necessary.
3. If the MCE maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that the authorization has been denied. If the provider is out-of-network, the provider must also explain that covered services may be available without cost in-network if authorization is provided.
4. The member must be informed of the right to contact the MCE to file an appeal if the member disagrees with the decision to deny authorization.
5. The providers must inform members of member responsibility for payment if the member chooses to or insists on receiving the service without authorization.

If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:

- The waiver is signed only after the member receives the appropriate notification stated in requirements 3 and 4.
- 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 nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of noncovered services.
- The waiver must specify the date the services are provided and the services that fall under the waiver's application.
- The provider must have the right to appeal any denial of payment by the MCE for denial of authorization.

Nothing on this list should be interpreted as preventing payment of covered services for HIP members with POWER Account funds before the member's deductible is met. However, if the MCE permits providers to bill members for services that require authorization, but for which authorization has been denied (as outlined previously), the POWER Account funds cannot be used to reimburse the provider for the noncovered services.

8.18.3 Future Recovery Effort Due to Retroactive Medicare Eligibility

The MCEs must include the language below in any future recovery effort due to retroactive Medicare eligibility. This ensures providers are aware of their rights when billing Medicare beyond Medicare's standard timely filing limits and has helped Traditional Medicaid cut down on provider complaints.

> *Medicare regulations 42 C.F.R. §424.44(b) allows for exceptions to the 1 calendar year time limit for filing Medicare claims. Retroactive Medicare entitlement involving state Medicaid Agencies, where a state Medicaid Agency recoups payment from a provider or supplier 6 months or more after the date the service was furnished to a dually eligible beneficiary, is an allowed exemption. Refer to Chapter 1, subsection 70.7 of the Medicare Claims Processing manual for qualifying exceptions and associated billing instructions.*

8.19 Disclosure of Physician Incentive Plan

The MCE may implement a physician incentive plan (PIP) only if:

- The MCE makes 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 enrollee.
- The MCE meets requirements for stop-loss protection, member survey, and disclosure requirements under *42 CFR 438.6*.
- The MCE 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.

Federal regulations *42 CFR 438.6*, *42 CFR 422.208*, and 42 *CFR 422.210* provide information about physician incentive plans, and the CMS provides guidance on its website. The MCE must comply with all federal regulations regarding PIPs and supply to the state information on its PIP, as required in the regulations and with sufficient detail to permit the state to determine whether the incentive plan complies with the federal requirements. The MCE must provide information about its PIP, on 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.

Section 9: Quality Management and Utilization Management

The managed care entity (MCE) must monitor, evaluate, and take effective action to identify and address any needed improvements in the quality of care delivered to members in the Healthy Indiana Plan (HIP) program by all providers in all types of settings. In compliance with state and federal regulations, the MCE must submit quality improvement data, including data that meets Healthcare Effectiveness Data and Information Set (HEDIS) standards for reporting and measuring outcomes, to the state that includes the status and results of performance improvement projects. Additionally, the MCE must submit information requested by the state to complete the *State's Annual Quality Strategy Plan* to the Centers for Medicare & Medicaid Services (CMS).

For purposes of this section, the following definitions apply:

- A *performance improvement project* is a plan to remediate an identified program deficiency in response to a sanction or action by the state.
- A *quality improvement project* is a planned strategy for program improvement and is incorporated into the MCE's *Quality Management and Improvement Program Work Plan*.

The MCE's medical director must be responsible for the coordination and implementation of the *Quality Management and Improvement Program*. The program must have objectives that are measurable, realistic, and supported by consensus among the MCE's medical and quality improvement staff. Through the Quality Management and Improvement Program, the MCE must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its Quality Management and Improvement Program, the MCE will develop incentive programs for both providers and members, with the ultimate goal of encouraging appropriate utilization of healthcare resources and improving health outcomes of HIP members.

As a part of the *MCE's Quality Management and Improvement Program*, the MCE must participate in the state's annual performance improvement program.

Communication and activities between the MCEs and the FSSA include, but are not limited to the following:

- Meetings
- Reports
- Quality improvement measures and studies

The MCE must meet the requirements of *42 CFR 438 subpart E* and the National Committee for Quality Assurance (NCQA), including but not limited to the following requirements, in developing its quality management program. The quality management program must ensure that it addresses the following:

- Assess quality and appropriateness of care provided to members with special needs, including all medically frail HIP members.
- 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.
- Produce new information and reports on quality of care at least annually.

The MCE's *Quality Management and Improvement Program* must:

- Include developing and maintaining an annual *Quality Management and Improvement Program Work Plan*, which sets goals, establishes specific objectives, identifies strategies and activities, monitors results, and assesses progress toward goals. Specific requirements for the *Quality Management and Improvement Program Work Plan* are outlined in the *MCE Reporting Manual*.
- Have in effect mechanisms to detect both underutilization and overutilization of services. The actions the MCE 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 the name of departments responsible for completing each task.
- Incorporate an internal system for monitoring services, including clinically appropriate data collection and management for clinical studies, internal quality improvement activities, assessment of the special needs population, and other quality improvement activities requested by the state.
- Participate appropriately in clinical studies and use 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 MCE must act in accordance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or HealthWatch requirements.
- Collect measurement indicator data related to areas of clinical priority and quality of care. The state establishes areas of clinical priority and indicators of care. These areas may vary from one year to the next and from program to program. The areas will reflect the needs of the HIP population. Examples of areas of clinical priority include:
  - HIV and Hepatitis C Care
  - Behavioral health and physical healthcare coordination
  - Immunization rates
  - EPSDT services, including developmental screening rates
  - Prenatal care
  - Emergency department 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/or biopsies
  - Integrated medical and behavioral health utilization
- Report any national performance measures developed by the CMS, such as CMS Core Measures. The MCE must develop an approach for meeting the performance levels established by the CMS on release of the national performance measures, in accordance with *42 CFR 438.330(a)*, which allows the CMS to specify measures and topics for performance improvement projects
- Establish procedures for collecting and ensuring accuracy, validity, and reliability of performance measures that are consistent with protocols developed in the public or private sector. The CMS website at cms.gov contains an example of available protocols.
- Develop and maintain a physician incentive program.
- Develop a member incentive program to encourage members to be personally accountable for their own healthcare and health outcomes. Targeted areas of performance could include the appropriate use of emergency department 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 HEDIS rates. The HEDIS audit and report must be based on the NCQA methodology for sampling of HEDIS data.
- Conduct a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and report results to the state annually. The CAHPS must be based upon the NCQA methodology for sampling CAHPS data.
- Include a provider relations project annually.
- Participate in other quality improvement activities, including External Quality Reviews, to be determined by the state.

9.1 Quality Management and Improvement Program Documents

The MCE's Quality Management and Improvement Committee, in collaboration with the MCE's medical and pharmacy directors, must develop, approve, monitor and evaluate a Quality Management and Improvement Program Description, Work Plan, and Annual Evaluation.

The *Quality Management and Improvement Program Description* will clearly outline an outcome- driven strategy for quality improvement. The strategy will include a detailed description of new goals and objectives based on findings from a variety of sources including but not limited to QI activities, EQR findings, Grievance and Appeals, survey results and clinical and service quality indicators. The program description will clearly reflect alignment with OMPP Quality Strategy with a focus on health equity and special populations. The Quality Management and Improvement Program Description will be submitted to OMPP annually.

The *Quality Management and Improvement Work Plan* is a working document that will track a broad range of activities and timelines as well as program goals and activities to support each goal. The work plan will be updated at least quarterly and will be submitted to OMPP quarterly. This document will include elements outlined by NCQA as well as line items to monitor activity and performance of closed and open quality improvement projects. The work plan must identify the MCE's quality management goals and objectives specific to HIP and include a timeline of activities and assessments of progress toward meeting the goals. The MCE must be prepared to periodically report on its quality management activities to the state's Quality Strategy Committee.

The *Quality Management and Improvement Program Evaluation* is an annual comprehensive quality program evaluation that highlights health outcomes gains over the year. It also documents areas where goals were not met and identifies barriers that contributed to unmet goals. The results of the Quality Management and Improvement Program Evaluation will drive updates to the subsequent year program description. The plan must meet NCQA standards for reporting and measuring outcomes.

Further, as demonstrated in these Quality Management and Performance Improvement documents, the MCE must also:

- Establish program goals and objectives specific to the HIP population to improve the MCE's functioning, improve the delivery of healthcare services, and improve health outcomes and health equity.
- Identify specific tasks, individuals responsible, and timelines for each quality improvement activity.
- Demonstrate an effort toward implementing enrollee-targeted or PMP-targeted programs that result from areas for improvement identified through readiness reviews, focused studies, and internal quality improvement efforts.

- Demonstrate that its quality improvement program is integrated throughout the organization, and through any of its subcontractors when appropriate, for the purposes of assessment, evaluation, and implementation of modifications and changes.

The *MCE Reporting Manual* contains more information about the annual *Quality Management and Improvement Program Description, Work Plan and Evaluation*.

9.1.1 External Quality Review

Pursuant to federal regulation, the state must arrange for an annual, external independent review of each MCE's quality of, timeliness of, and access to healthcare services. The MCEs will cooperate with and participate in the External Quality Review (EQR), including providing all information required for the review in a time frame and form requested by the external quality review organization. Subsequently, the MCE's *Quality Management and Improvement Program* must incorporate and address findings from all external quality reviews.

9.2 Incentive Programs

The state requires MCEs to participate in a pay-for-outcomes program that focuses on rewarding MCEs' efforts to improve quality and outcomes for HIP members. The state will provide, at minimum, financial performance incentives to MCEs based on performance targets in priority areas established by the state.

The state reserves the right to revise measures on an annual basis and will notify the MCE of changes to incentive measures.

9.2.1 Provider Incentive Programs

The MCE must establish a performance-based incentive system for its providers. The MCE will determine its own methodology for incentivizing providers. The MCE must obtain the state approval before implementing its provider incentive program and before making any changes thereto. The state encourages creativity in designing pay-for-performance programs.

If the MCE offers financial incentives to providers, these payments must be above and beyond the standard IHCP fee schedule.

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 MCE must comply with all federal regulations regarding the physician incentive plan and supply to the state information on its plan as required in the regulations and with sufficient detail to permit the state to determine whether the incentive plan complies with the federal requirements. The MCE must 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 must comply with the following requirements:

- The MCE 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.
- The MCE meets requirements for stop-loss protection, member survey and disclosure requirements under *42 CFR 438.10(f)(3)*.

9.2.2 Member Incentive Programs

MCEs must establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or nonfinancial. The MCE will determine its own methodology for incenting members. For example, the MCE 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, case management or care management program
- Making healthy lifestyle decisions such as tobacco cessation or losing weight
- Completing a health screening
- Participation in tobacco cessation
- Participation in substance use disorder treatment
- Participation in chronic disease management

The MCE may not offer gifts or incentives greater than $200 for each individual per incentive and $300 per year per individual. The MCE may petition the state for authorization to offer items or incentives greater than $200 for each individual per incentive and $300 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 the state. HIP has its own preventive care services as established each year. The state will review the preventive care services every year and notify the MCEs as needed. The incentives offered to beneficiaries must be proportionate to the value of care provided. The state will not approve raffles as these are regulated activities subject to Indiana gaming law. All programs not tied to preventive care will remain subject to the $200 individual per incentive and $300 annual limits.

Member incentive programs may not be advertised to non-members. The state will not approve any mass marketing materials that describe member incentive programs. MCEs must only advertise incentives to current members through mediums such as the member handbook or letters or telephone calls directed to current membership.

To obtain approval for any member incentive programs and all enhanced services proposals, MCEs must use the established Enhanced Services Review process to facilitate the state's review. The MCE is responsible for describing the goals of the program, time frame, target population, program criteria, outreach methodology, incentives proposed and monitoring and evaluation methods. Additionally, the MCE must demonstrate that the incentive proposed does not surpass the value of the preventive care service provided. Petitions to provide enhanced incentives for preventive care are reviewed on a case-by-case basis, and the state retains full discretion in determining whether the enhanced incentives is approved.

In any member incentive program, the incentives must be tied to appropriate utilization of health services and/or health-promoting behavior. For example, the member incentive programs can encourage responsible emergency department use or preventive care utilization. MCEs must develop member incentives designed to encourage appropriate utilization of healthcare services, increase adherence to keeping medical appointments, and encourage the receipt of healthcare services in the appropriate treatment setting. Additionally, the MCE must comply with all marketing provisions in the *42 CFR 438.104*, as well as federal and state regulations regarding inducements. Examples of appropriate rewards include:

- Gift certificates for groceries
- Telephone cards
- Gifts such as diaper bags or new baby welcome kits

The MCE must obtain the state approval before implementing its member incentive program and before making any changes thereto.

9.2.3 Notification of Pregnancy Incentives

The state implemented the Notification of Pregnancy (NOP) process to encourage MCEs and providers to complete a comprehensive risk assessment (such as an NOP form) for pregnant members. NOP requirements and conditions for payment are set forth in *Notification of Pregnancy*. Only one assessment should be completed per member per pregnancy.

The provider is responsible for completing the standard NOP form, including member demographics, any high-risk pregnancy indicators, and basic pregnancy information. The MCE receiving the NOP must contact the member to complete a comprehensive pregnancy health risk assessment within 21 calendar days of receiving a completed NOP form from the provider.

To be eligible for the provider incentive payment, the Notification of Pregnancy form must be submitted by providers via the Portal within five calendar days of the visit during which the NOP form was completed. The state reimburses the MCE for NOP forms submitted according to the standards in the NOP chapter. This reimbursement amount must be passed on to the provider that completed the *NOP Process* section. An additional amount is transferred to a bonus pool. The MCE is eligible to receive bonus pool funds based on achievement of certain maternity-related targets as outlined in the MCE contract with the state.

The MCE must have systems and procedures in place to accept NOP data from the state 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 MCE will assign pregnant members to a risk level and enter the risk level information into the Portal within 12 calendar days of receiving NOP data from the state fiscal agent.

9.3 Utilization Management Program

The State has established a mandatory Utilization Management hierarchy that will be effective April 1, 2023 (see below). Therefore, the current policy allowing each MCE to establish their own policy will be null. MCEs must ensure Care Management teams are planning for and will implement this important change at the end of Quarter 1 of 2023.

9.3.1 Current Medical Criteria – to be retired by 3/31/2023

The MCE must operate and maintain its own utilization management program. The MCE may limit coverage based on medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose. The MCE shall include utilization management measurements in their Quality Management and Improvement Program Work Plan. The MCE is prohibited from arbitrarily denying or reducing the amount, duration, or scope of required services, solely because of diagnosis, type of illness, or condition. The MCE will not refer members to publicly supported health care resources as a means of avoiding costs.
The MCE must establish and maintain medical management criteria and practice guidelines, in accordance with federal and state regulations, based on valid and reliable clinical evidence or consensus among clinical professionals. The MCE must consider the needs of its members.

Where OMPP has criteria or guidelines in place, the MCE cannot have criteria or guidelines that are more restrictive. The MCE must use non-company customized InterQual or Milliman Care Guidelines (MCG) clinical guidelines. For areas not addressed by IHCP criteria and MCG/InterQual, the MCE may develop their own practice guidelines and criteria, but it must be approved by the state and made available to the state. Hierarchy for clinical criteria and guidelines:

1. IHCP Medical Policy Manual, Provider Reference Modules
2. MCG or InterQual criteria
3. Individual MCE medical policies, with prior state approval, when no criteria for UM review in the previous two bullet points exist
4. Published peer-reviewed literature

The following are the Fee-for-Service Criteria to be used for Hoosier Care Connect:

- ABA Therapy: http://provider.indianamedicaid.com/ihcp/Bulletins/BT201867.pdf and http://provider.indianamedicaid.com/ihcp/Bulletins/BT201953.pdf
    - Clarification: For PA determination – MCG Mental Health and Addictions Module- *Updated ABA policy is in draft currently in review process*
- Drug Testing: http://provider.indianamedicaid.com/ihcp/Bulletins/BT201846.pdf
- EndoPredict – Breast Cancer: http://provider.indianamedicaid.com/ihcp/Bulletins/BT202010.pdf
- Hysterectomies: http://provider.indianamedicaid.com/ihcp/Bulletins/BT201976.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
- Urine Drug Testing: http://provider.indianamedicaid.com/ihcp/Bulletins/BT202183.pdf

9.3.2 Mandatory Medical Criteria Hierarchy – Effective 04/01/23

Beginning April 1, 2023, Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise will follow the same utilization management medical criteria hierarchy for all managed care programs. Therefore, managed care programs will retire all customized guidelines by April 1, 2023, and ensure that any authorization reviewed on or after April 1, 2023, will be reviewed with consideration to the outlined hierarchy. Refer to IHCP Bulletin 2022117 dated December 20, 2022.

The following utilization management medical criteria hierarchy will be effective for all managed care programs beginning April 1, 2023.

For select items, MCEs must use IHCP Policy as outlined below. For all other items where OMPP has criteria or guidelines in place, the MCE cannot have criteria or guidelines that are more restrictive. The MCE 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 MCE may develop their own practice guidelines and criteria, but it 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 our 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.
    a. **MCEs must follow IHCP Policy (FFS criteria) exactly for these below items:**

- ABA Therapy: Bulletins
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT201867.pdf ,
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT201953.pdf,
  Module - https://www.in.gov/medicaid/providers/files/behavioral-health-services.pdf

- Drug Testing: Bulletins-
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT201846.pdf ,
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202183.pdf,
  Module - https://www.in.gov/medicaid/providers/files/laboratory-services.pdf

- EndoPredict-Breast Cancer: Bulletin
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202010.pdf

- Hysterectomies: Bulletin
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT201976.pdf ,
  Module - https://www.in.gov/medicaid/providers/files/obstetrical-and-gynecological-services.pdf

- ReliZorb: Bulletin
  http://provider.indianamedicaid.com/ihcp/Banners/BR202050.pdf

- Speech Generating Devices: Bulletin
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202012.pdf

- Spinal Stenosis: Bulletin-
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT2020111.pdf

- Transplants: Bulletin
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202019.pdf ,
  Module - https://www.in.gov/medicaid/providers/files/surgical-services.pdf

- Bariatric Procedures: Bulletin -
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202240.pdf ,
  Module - https://www.in.gov/medicaid/providers/files/surgical-services.pdf

- Oxygen Usage: Bulletin -
  http://provider.indianamedicaid.com/ihcp/Bulletins/BT202242.pdf ,
  Module: https://www.in.gov/medicaid/providers/files/durable-and-home-medical-equipment-and-supplies.pdf

6. Non-Customized National Clinical Guidelines – The MCE 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).
   o If an item is covered by MCG or InterQual—the MCE must use the applicable MCG or InterQual guideline in lieu of an MCE-derived guideline.
   o 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. MCE-derived Guidelines (must be pre-approved by the state)
8. Professional Society Guidelines—Guided by published peer-reviewed literature (can supersede National and MCE-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 MCEs with appropriate notice.

Established Utilization Management policy that is current and shall remain in policy:

The MCE must have sufficient staff with clinical expertise and training to interpret and apply utilization management criteria to providers' requests for healthcare or service authorizations. Utilization management staff must receive ongoing training regarding interpretation and application of the utilization management guidelines. The MCE must be prepared to provide a written training plan, which must include dates and subject matter, as well as training materials, upon request by the state.

If the MCE chooses to use separate medical policy for physical health and behavioral health services, the MCE must demonstrate that using separate policy would have no negative impact on members and would not otherwise violate the MCE's requirements under the MHPAEA. Pursuant to *42 CFR 438.210(b)*, the MCE must consult with contracting healthcare professionals in developing medical policy; the MCE must also have mechanisms in place to ensure consistent application of review criteria for authorization decisions and must consult with the provider that requested the services, when appropriate. The MCE must conspicuously publish on their member and provider websites which national clinical policy (MCG or InterQual) they utilize for PA/UM adjudication.

MCEs must publish their prior authorization procedures on the MCE website at least 45 days before the effective date. Any updates must be published at least 45 days prior to the effective date. These procedures must include all information necessary for a provider to submit a prior authorization (PA) request. The state may waive certain administrative requirements, including prior authorization, to the extent that such waivers are allowed by law and are consistent with policy objectives. The MCE may be required to comply with such waivers and are provided with prior notice by the state.
The MCE 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.

The MCE must maintain an efficient utilization management program that integrates with other functional units and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures in place that:

- Identify over- and underutilization of emergency department, non-emergency medical transportation and other healthcare services
- Identify aberrant provider practice patterns (especially related to emergency department visits, inpatient services, transportation, drug utilization, preventive care and screening)
- Ensure active participation of a utilization review committee
- Evaluate efficiency and appropriateness of service delivery
- Incorporate subcontractors' performance data
- Facilitate program management and long-term quality
- Identify critical quality-of-care issues
- Monitor pharmacy utilization

The MCE must monitor utilization through retrospective reviews and identify areas of high and low utilization and identify key reasons for the utilization patterns. The MCE must identify those members who are high users of emergency department services and/or other services and perform the necessary outreach and screening to ensure 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 MCE must also use this data to identify additional disease management programs that are needed. Any

member with emergency department utilization at least three standard deviations outside the mean for the population group must be referred to case management or care management.
The MCE must define service authorizations in a manner that at least includes members' requests for services. The MCE's utilization management policies and procedures must include time frames for the following:

- 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
- Notifying providers and members of the MCE's decisions on initial prior authorization requests and determinations of medical necessity
- Notifying providers and members of the MCE's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity

The MCE's utilization management program must link members to disease management, case management and care management. The MCEs utilization management program must also encourage health literacy and informed, responsible medical decision making. For example, MCEs must develop member incentives designed to encourage appropriate utilization of healthcare services and increase adherence to keeping medical appointments and obtaining services in the appropriate treatment setting. MCEs are also responsible for identifying and addressing social barriers that may prohibit a member's ability to obtain preventive care.

As part of its utilization review, the MCE must monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards such as those published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, and the state's recommended preventive care guidelines. The MCE must develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards.

The MCE must also monitor the pharmacy utilization of all its members.
To monitor under- or overutilization of behavioral health services, the state requires MCEs to provide separate utilization reports for behavioral health services. In particular, the MCE must monitor use of services for its members with special needs and those with diagnoses of severe mental illness or substance abuse. Reporting requirements are located in the Reporting Manual.

To monitor under- or overutilization of behavioral health services, the state requires MCEs to provide utilization reports for behavioral health services specific to the HIP line of business; report specifications are outlined in the *MCE Reporting Manual*. In particular, the MCE must monitor use of services for its members with special needs and those with diagnoses of severe mental illness or substance abuse. The behavioral health services report must also separately identify the utilization of HIP members designated as medically frail.

9.3.3 The Right Choices Program

The Right Choices Program (RCP) identifies members who use covered services more extensively than their peers and are potentially overusing or abusing services. 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 MCE provides appropriate disease management, care management, or complex case management services to RCP members. Program policies for RCP are set forth by the state and delineated in the *Right Choices Program* module. The MCE must comply with the program policies set forth in the *Right Choices Program* module.

The MCEs contracted with the IHCP serve as the RCP Administrators on behalf of the state for members in managed care programs. The MCE is responsible for RCP duties as outlined in the *Right Choices Program*

Administrator Manual at in.gov/medicaid/partners/mco. The MCE's responsibilities include, but are not limited to, the following:

- Evaluate claims (including medical and pharmacy claims), medical information, referrals, and data to identify members to be enrolled in RCP—before enrolling a member in RCP, the MCE must ensure a physician, pharmacist, or nurse confirms the appropriateness of the enrollment.
- Document member enrollment and compliance in Portal.
- Enroll members in RCP.
- Provide written notification of RCP status to such members and their assigned primary physicians, pharmacies, and/or hospitals.
- 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 their treatment plan to determine continuation or termination of RCP restrictions. The state must make available utilization data about the MCE's RCP members to assist the MCE in its monitoring duties.
- Notify the state of members who are being reported to the Family and Social Services Administration (FSSA) Bureau of Investigation for suspected or alleged fraudulent activities.
- Provide reports about RCP to the state upon request.
- Cooperate with the state in evaluation activities of the program by providing data and/or feedback when requested by the state.
- Meet with the state about RCP implementation as requested by the state.
- Develop, obtain the state approval of, and implement internal policies and procedures regarding the MCE's RCP administration.

The state monitors the MCE's compliance with RCP duties set forth in the *Right Choices Program* provider reference module through its monthly on-site visits and/or external quality review activities. The MCE may be subject to noncompliance remedies if the MCE fails to comply with RCP duties set forth in the MCE's contract with the state and the *Right Choices Program* provider reference module. The state reserves the right to review all data and utilization figures for the MCE's RCP membership, including the number of RCP members who have had more than one emergency department visit in a 30-calendar day period, in assessing the effectiveness of the MCE's RCP program administration.

9.3.4 Authorization of Service and Notice of Action

Professionals with clinical expertise in the treatment of a member's condition must make all decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Only licensed physicians and nurses may deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested. The MCE must not provide compensation or other incentives to utilization management staff or subcontractors for denying, limiting, or discontinuing medically necessary services per 42 CFR 438.210(e).

The state 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 MCE may be required to comply with such waivers and will be provided with prior notice by the state. If the MCE delegates some or all of its prior authorization function to subcontractors, the MCE must conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the MCE's policies and procedures and state and federal law.

As part of utilization management, the MCE must facilitate its PMPs' requests for authorizing primary and preventive care and must assist PMPs in providing referrals for specialty services. In accordance with federal regulations, the process for authorizing services must comply with the following requirements:

- Second Opinions – In accordance with *42 CFR 438.206(b)(3)*, the MCE must comply with all member requests for second opinions from qualified professionals. If the provider network does not include a provider that is qualified to give a second opinion, the MCE must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.
- Special Health Care Needs – In accordance with *42 CFR 438.208(c)*, the MCE must allow members with special Health Care needs who require courses of treatment or regular care monitoring to directly access specialists for treatment via established mechanisms, such as standing referrals from the members' PMPs or an approved number of visits. Treatment provided by specialists must be appropriate for the member's condition and needs.
- Women's Health – In accordance with *42 CFR 438.206(b)(2)*, the MCE must provide female members with direct access to a women's health specialist within the network to provide women's covered routine and preventive healthcare services. This is in addition to female members' designated sources of primary care (if those sources are not women's health specialists). The MCE must have an established mechanism, such as standing referrals from members' PMPs or an approved number of visits, to permit female members direct access.
- The MCE must notify the requesting provider and provide written notice to members of any decisions to deny service authorization requests, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member must be given within the time frames required in this section and in *42 CFR 438.404.* Notification must be made to the member by the last day of the decision time frame if a decision is still pending,
- The MCE must submit all PA notification form letters to the state through the document review process. The letters must meet the requirements of *42 CFR 438.10(c)* and *(d)* and Section 9.3 of the *Healthy Indiana Plan Scope of Work* regarding language, oral interpretation, and format for member materials, and must clearly explain the following:
  - The qualifications of the reviewer
  - The guidelines used and reason for denial
  - The action the MCE 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 benefit determination
  - The member's or the provider's right to request an appeal with the MCE and the process for doing so, including information on exhausting the MCE's one level of appeal
  - If the member has exhausted the MCE's appeal process, the member's right to request an FSSA hearing and the process for doing so
  - Circumstances under which expedited resolution is available and how to request it
  - The member's right to have benefits continue until 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
  - The provider's right for a peer-to-peer utilization review conversation with the reviewer and timeline for requesting the peer-to-peer review.

The MCE must notify members of standard authorization decisions as expeditiously as required by the member's health condition, not to exceed seven calendar days after the request for services. An extension of as many as 14 calendar days is permitted if the member or provider requests an extension, or if the MCE justifies to the state a need for more information and explains how the extension is in the member's best interest. Extensions require written notice to members and must include the reason for the extension and the member's right to file an appeal.

Unless otherwise provided in *405 IAC 10-7-12*, if the MCE fails to respond to a member's prior authorization request within seven calendar days of receiving all necessary documentation, the authorization is deemed to be granted.

For situations in which a provider indicates, or the MCE determines, that following the standard time frame could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the MCE must expedite the authorization decision and provide notice as quickly as the member's condition requires and no later than forty-eight (48) hours after receiving the request. The MCE may extend the forty-eight (48) hours to as many as 14 calendar days if the member requests an extension, or if the MCE justifies a need for additional information and how the extension is in the member's best interest. The MCE will be required to provide its justification to OMPP upon request.

The MCE must notify the member of a decision to deny payment on the date of the MCE's decision if the member is liable for payment.

The MCE must notify members of decisions to terminate, suspend, or reduce previously authorized covered services, including decisions to transfer members between HIP benefit plans that result in changes to covered services, at least 10 calendar days before the date of action, with the following exceptions:

- Notice is shortened to five calendar days if probable member fraud has been verified by the Indiana Office of the Inspector General or Attorney General.
- Notice may occur no later than the date of the action if any of the following occurs:
  - The death of a member.
  - The MCE receives a signed, written statement from the member requesting termination of service or giving information requiring termination or reduction of services (the member must understand the result of supplying this information).
  - The member is admitted to an institution and is consequentially ineligible for further services.
  - The member's address is unknown, and there is no forwarding address.
  - The member is accepted for Medicaid services by another jurisdiction.
  - The member's physician prescribes a change in the level of medical care.
  - An adverse determination is 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 30 days (applies only to adverse actions for nursing facility transfers).

9.3.5 Requirements for Tracking Prior Authorization Requests

The MCE must track all prior authorization requests in their information system. All notes in the MCE's prior authorization tracking system must be signed by clinical staff and include the appropriate suffix, such as registered nurse (RN), medical doctor (MD), and so forth. For prior authorization approvals, the MCE must provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the MCE's information system:

- Name of caller
- Title of caller
- Date and time of call
- Prior authorization number

For all denials of prior authorization requests, the MCE must maintain a record of the following information, at a minimum, in the MCE's information system:

- Name of caller
- Title of caller
- Date and time of call
- Clinical synopsis inclusive of:
  - Time frame of illness or condition
  - Diagnosis
  - Treatment plan
- Clinical guidelines or other rational supporting the denial (such as insufficient documentation)

9.3.6 Objection on Moral or Religious Grounds

If the MCE 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 must furnish information about the services it does not cover as follows, in accordance with *42 CFR 438.102(b):*

- To the state if it adopts the policy during the term of the contract
- To potential members before and during enrollment
- To members within 90 calendar days after adopting the policy with respect to any particular service, but at least 30 calendar days before the effective date.

9.3.7 Utilization Management Committee

The MCE must have a utilization management committee directed by the MCE's medical director. The same committee must be responsible for the MCE's Hoosier Healthwise and HIP lines of business. The committee is responsible for the following:

- Monitoring providers' requests for rendering healthcare services to its members.
- Monitoring the medical appropriateness and necessity of healthcare 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.
- Confirming that the MCE has an effective mechanism in place to respond within 1 hour to all emergency department providers, 24 hours a day, seven days a week:
  - After the MCE's member's initial emergency room screening, and
  - After the MCE's member has been stabilized and the emergency room provider believes continued treatment is necessary to maintain stabilization

9.4 Medical Management Standard Compliance

The MCE must also have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the plan's medical management standards.

The MCE must conduct periodic reviews of claims files and medical audits to determine the following:

- Treatment was consistent with diagnosis

- The treatment resulted in appropriate outcomes for participants with certain high-risk chronic or acute conditions (for example, asthma, hypertension, diabetes, otitis media, lead poisoning, drug dependency, and diseases preventable by routine immunization)
- The services provided emphasized preventive care and resulted in early detection
- The PMP appropriately referred members for specialty care
- Other compliance and appropriateness of services were provided

The state recommends that MCEs implement internal desk review procedures. Utilization review is emphasized particularly for outlier cases. MCEs are also required to provide the state with additional information to assist in investigation of outlier and other unusual cases.

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Section 10: Program Integrity

10.1 Program Integrity Plan

Pursuant to *42 CFR 438.608*, which sets program integrity requirements, the MCE 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 MCE's compliance plan. The Program Integrity Plan shall be submitted annually and upon request by the OMPP PI Unit, and updated quarterly, or more frequently if required by the OMPP Program Integrity (PI) Unit and be submitted to the OMPP. The PI Plan and/or updates to the PI Plan shall be submitted through the reporting process to the OMPP, who shall forward to the OMPP PI Unit, 10 business days before scheduled meetings discussing the Plan. The Plan shall include in its PI Plan provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of MCE's providers, vendors, and subcontractors (including but not limited to Pharmacy Benefits Managers, vision, transportation, dental) and MCE 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. The Plan should document that the Compliance Officer and SIU Manager shall meet with the OMPP PI Unit at a minimum of quarterly and as directed by the FSSA PI Unit.
- 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 the CMS and FSSA. Training should also focus on recent changes in rules.
- A risk assessment of the MCE's various fraud and abuse/program integrity processes. A risk assessment shall also be submitted on an 'as needed' basis and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment and fines), is issued on a provider with concerns of fraud and abuse. The MCE shall inform the OMPP PI Unit of such action and provide details of such financial action. The assessment shall also include a listing of the MCE's 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
  - Automated post-payment claims edits
  - Types of desk audits on post-processing review of claims
  - Reports for provider profiling and credentialing used to aid program and payment integrity reviews
  - Surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services
  - Provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials
  - References in provider and member material regarding fraud and abuse referrals

  - Provisions for the confidential reporting of PI Plan violations to the designated person
  - 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 MCE are protected and that there is no retaliation against such persons.
- Specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating 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 Unit and pursuant to the Program Integrity Operations section in *Quality Improvement and Utilization Management*.
- Assurances that no individual who reports MCE's potential violations or suspected fraud and abuse is retaliated against.
- Policies and procedures for conducting 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 to ensure and verify that the MCE, managing employees, subcontractors, and providers are not affiliated with any organizations or individuals debarred, suspended, or otherwise excluded by federal agencies or from participating in any contract paid with federal funds.
- Provisions for maintaining fraud and abuse-dedicated hotlines, website or email addresses, mailing addresses, facsimile numbers, and internal mailboxes for members, providers, MCE staff, and the general public to report instances of suspected fraud and abuse.
- 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.

On a quarterly basis, the MCE must submit a high-level progress report to the state, which outlines the MCE's program integrity-related activities and findings, as well as identifies the MCE's progress in meeting program integrity-related goals and objectives.

The MCEs must disclose healthcare-related criminal convictions from providers and all affiliated parties as specified in the 42 CFR 455.106 to the state and MFCU. MFCU will notify the Department of Health and Human Services, Office of Inspector General (OIG).

In the event of provider fraud, contact the state with a carbon copy to your appropriate contract compliance officer and surveillance and utilization review (SUR). In the event of member fraud, please contact with a copy to FSSA Bureau of Investigation.

10.1.1 Additional Program Integrity Requirements

The Indiana Office of the Attorney General Medicaid Fraud Control Unit (MFCU) is the state agency responsible for the investigation of provider fraud in the Indiana Medicaid program.

The OMPP Program Integrity (OMPP PI) Unit 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 Unit 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.

The MCE, as well as its subcontractors and providers, whether contract or noncontract, 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 the 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 years, and at any time upon request.

Pursuant to *42 CFR 455.104-106*, the MCE must disclose to the state and to HHS-OIG the following information on ownership, control and persons convicted of crimes:

- The name and address of each person with an ownership or controlling interest in the MCE
- The name and address of each person with an ownership or controlling interest in a sub-MCE in which the MCE has direct or indirect ownership of 5% or more
- Whether any person who has an ownership or controlling interest in the MCE and subcontractor are related to another as a spouse, parent, child, or sibling
- Name of any other Medicaid provider in which a person with an ownership or controlling interest in the MCE also has an ownership or controlling interest
- Name of any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because participation on any program established under titles V, XVIII, or XX of the *Social Security Act* in which a person with an ownership or controlling interest in the MCE also has an ownership or controlling interest
- Any person with ownership or control interest in the MCE who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs
- Any person who is an agent or managing employee of the MCE who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs
- Any person with ownership or control interest in a provider contracted with an MCE who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs
- Any person who is an agent or managing employee of a provider contracted with an MCE who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

The MCE must develop policies and procedures for notifying the state of the aforementioned disclosures that includes procedures for providing, at a minimum, quarterly updates, as well as immediate updates if any changes occur.

10.2 Program Integrity Operations

- The MCE must 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 MCE must 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.
- The MCE must have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud, and abuse issues of MCE's providers, vendors, and subcontractors (including pharmacy benefits managers) and MCE itself.

The MCE is required to conduct and maintain at a minimum the following operations and capabilities. The MCE must 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 MCE's structure shall have the ability to make referrals to the OMPP PI Unit 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, and so forth.
- The MCE must also have effective procedures for timely reviewing, investigating, and processing such referrals.
  - The MCE will suspend all payments to a provider after the Agency determines that there is a credible allegation of fraud and has provided the MCE 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 MCE'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.
- The MCE shall submit to FSSA for approval the criteria used for its review of its members and the referral of members to the Right Choices Program.

10.3 Program Integrity Reporting

The MCE, and all subcontractors, must cooperate with all appropriate state and federal agencies, including the Indiana MFCU and the OMPP PI Unit, in investigating fraud and abuse. Cooperation includes making a timely referral of potential credible allegations of fraud as well as providing the OMPP PI Unit and the Medicaid Fraud Control Unit with any documentation requested in a timely manner. The MCE shall have methods for identification, investigation, and referral of suspected fraud cases (*42 CFR 455.13, 455.14, 455.21*). The MCE must provide an Audit Report to the OMPP and the OMPP PI Unit. This report documents all provider and member-specific program integrity activities of the MCE (i.e., the specific application of the Program Integrity Plan provisions to identify specific provider and member waste, fraud, and abuse).

10.3.1 Reporting Waste, Fraud, and Abuse

The MCE must immediately report all suspected or confirmed instances of waste, fraud and abuse to the OMPP and the PI Unit.

- The MCE shall use the *Reporting Forms* provided by the OMPP for all such reporting or such other form as may be deemed satisfactory.
- The MCE shall be subject to noncompliance remedies under this Contract for willful failure to report fraud and abuse by providers, Medicaid beneficiaries/members, or applicants to the OMPP PI Unit as appropriate.

- All suspected cases of waste, fraud, and abuse must be discussed at the Managed Care-Program Integrity coordination meeting following the OMPP PI Unit's receipt of the report unless otherwise directed by the OMPP PI Unit.

10.3.2 Investigation of Waste, Fraud, and Abuse

The MCE must 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 MCE 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
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident
- The MCE shall promptly provide the results of its preliminary investigation to the OMPP PI Unit or to another agency designated by the OMPP PI Unit
- The MCE 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 MCE 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.

10.3.3 Credible Allegation of Fraud

The MCE must comply with *42 CFR 455.23* by suspending all payments to a provider after the Agency determines that there is a credible allegation of fraud and has provided the MCE with notice of a payment suspension.

10.3.4 Audit Report

On a quarterly basis, and as otherwise directed by the OMPP PI Unit, the MCE must submit a detailed Audit Report to the OMPP which outlines the MCE's program integrity-related activities, as well as identifies the MCE's progress in meeting program integrity-related goals and objectives. The Audit Report documents all provider- and member-specific program integrity activities of MCE (for example, the specific application of Program Integrity Plan provisions to identify specific provider and member waste, fraud and abuse), as documented in the following:

- 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 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. **In accordance with the *Affordable Care Act* and FSSA policy and procedures, the MCE shall report overpayments made by FSSA to the MCE as well as overpayments made by the MCE to a provider and/or subcontractor.**
- The *Audit Report* shall identify projected upcoming activity, including the top 20 providers on MCE's list for audit, and the types of audits envisioned.

- Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the OMPP PI Unit) must be submitted in the *Audit Report*.
- The OMPP PI Unit shall review and approve, approve with modifications, or reject the *Audit Report* and specify the grounds for rejection.

In accordance with 42 CFR 438.608(d)(3), the MCE shall report annually to the state on the recoveries of overpayments.

10.3.5 HIPAA or Other Security Breach

The MCE shall notify the OMPP within one business day upon discovery of a HIPAA or other security breach.

10.4 Program Integrity Overpayment Recovery

The MCE 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 MCE.

The MCE will have policies and procedures in place to fully comply with 42 CFR 438.608. The MCE must maintain relevant documentation for a minimum of seven (7) years. 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 Unit, the FSSA may recover any identified overpayment directly from the provider or may require MCE to recover the identified overpayment and repatriate the funds to the state Medicaid program as directed by the OMPP PI Unit. The OMPP PI Unit may also take disciplinary action against any provider identified by the MCE or the OMPP PI Unit as engaging in inappropriate or abusive billing or service provision practices.

If a fraud referral from an MCE generates an investigation and/or corresponding legal action results in a monetary recovery to IHCP, the reporting MCE is 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 MCE's share of recovery is 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 Unit operations associated with the investigation, and its actual documented loss (if any). The state will pay to the MCE the remainder of the recovery, not to exceed the MCE's actual documented loss. Actual documented loss of the parties is 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 MCE about potential settlement. The state may consider the MCE'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 MCE shall survive expiration of the Contract and remain in effect until final resolution of a matter referred to the IMFCU by the MCE under this section.

If the state makes a recovery from a fraud investigation and/or corresponding legal action where the MCE has sustained a documented loss but the case did not result from a referral made by the MCE, the state shall

not be obligated to repay any monies recovered to the MCE, but may do so at its discretion. Funds recovered as a result of a multi-state fraud investigation/litigation, however, is shared with MCE as prescribed for funds recovered as a result of MCE's fraud referral absent extenuating circumstances.

The MCE is prohibited from the repayment of state-, federally-, or MCE-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, by the state 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
- When the issue, services, or claims that are the basis of the repayment have been or are currently being investigated by the OMPP PI Unit, the Federal Unified Program Integrity Contractor (UPIC), Indiana MFCU, or Assistant United States Attorney (AUSA), are the subject of pending federal or state litigation, or have been/are being audited by the state Recovery Audit MCE (RAC)

This prohibition described previously shall be limited to a specific provider, for specific dates, and for specific issues, services or claims. The MCE must check with the OMPP PI Unit before initiating any repayment of any program integrity related funds to ensure that the repayment is permissible.

10.5 Auditing Program Integrity Operations

The OMPP PI Unit may conduct audits of MCE's SI Unit activities to determine the effectiveness of the MCE'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 Unit may issue a corrective action or performance improvement plan and outline timelines for improvement measures. Failure to adhere to operational improvement measures may result in the state's imposing liquidated damages up to the amount of overpayments recovered from the MCE's providers by OMPP PI Unit audits for the preceding calendar year, or imposing other noncompliance remedies including liquidated damages as outlined in the contract.

Section 11: Information Systems

The managed care entity (MCE) must have a management information system (MIS) sufficient to support the Healthy Indiana Plan (HIP) program requirements. For example, the MCE must be prepared to submit all required data and reports accurately and completely in the format specified by the Office of Medicaid Policy and Planning (OMPP). The MCE must maintain an information system with capabilities to perform the data receipt, transmission, integration, management, assessment, and system analysis tasks described in this manual and in the MCE's contract with the state. The MCE's information system must integrate care management activities, state Personal Wellness and Responsibility (POWER) Account activities, including rollover, and HIP member benefit plan assignment, including any applicable medically frail designation or pregnancy diagnosis.

The MCE must have a plan for accessing and storing data files and records in a manner that is in keeping with *Health Insurance Portability and Accountability Act* (HIPAA), *45 CFR 162* and *164* requirements for confidentiality when transmitting and maintaining medical data.

The MCE's information system (IS) must support *Health Insurance Portability and Accountability Act* (HIPAA) Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier (NPI) requirements, and *Privacy and Security Rule* standards. The MCE's electronic mail encryption software for HIPAA security purposes shall provide no less protection than the state's electronic mail encryption software. If the state's technical requirements require a contract amendment, the state will work with MCEs in establishing the new technical requirements. The MCE must be capable of adapting to any new technical requirements established by the state, and the state may require the MCE to agree in writing to the new requirements. After the MCE has agreed in writing to a new technical requirement, any MCE-initiated change must be approved by the state and the state may require the MCE to pay for additional costs incurred by the state to implement the MCE-initiated change.

The MCE's IS plans for privacy and security shall include, but be not limited to:

- Administrative procedures and safeguards (*45 CFR 164.308*)
- Physical safeguards (*45 CFR 164.312*)
- Technical safeguards (*45 CFR 164.312*)

The MCE must make all collected information available to the state and, on request, to the Centers for Medicare & Medicaid Services (CMS). In accordance with the *Code of Federal Regulations (CFR)* at *42 CFR 438, subpart H*, the MCE must submit all data with the signatures of its financial officer and executive leadership (for example, president, chief executive officer, or executive director), certifying the accuracy, truthfulness, and completeness of the MCE's data.

The MCE must comply with all *Indiana Office of Technology (IOT) standards, policies, and guidelines*. All hardware, software, and services provided to or purchased by the state is 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 *Indiana Code (IC) 4-13.1.3*. Any deviation from these architecture requirements must be approved in advance and in writing by IOT. In addition to the IOT policies, the MCE must comply with all FSSA Application Security Policies. Any deviation from the policies must be approved in writing from the state.

The MCE must develop processes for development, testing, and promotion of system changes and maintenance. The MCE must notify the state at least 30 calendar days before the installation or implementation of minor software and hardware changes, upgrades, modifications or replacements. The MCE must notify the OMPP at least 90 calendar days before 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 MCE's capability to interface with the state or the state's contractors. The MCE must ensure that system changes or system upgrades are accompanied by a plan that includes a timeline, milestones, and adequate testing to be completed before implementation. The MCE must notify and provide such plans to the FSSA upon request, in the time frame and manner specified by the state.

11.1 Disaster Recovery Plans

Information system contingency planning must be developed in accordance with the MCE's contract with the state, as well as *45 CFR 164.308*. Contingency plans must include data backup plans, disaster recovery plans, and emergency mode of operations plans. For purposes of this policy, *disaster* means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the MCE's or its subcontracting entities' information system or claims processing system; or that affects the performance, functionality, efficiency, accessibility, reliability, or security of the system. Application and data criticality analysis, along with testing and revisions procedures must also be addressed in the MCE's contingency plan documents. The MCE 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 24 hours of identifying a disaster. The MCE must protect against hardware, software, and human error. The MCE must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file backups, and disaster recovery.

The MCE must maintain full and complete backup copies of data and software and must proficiently back up tapes or optical disks and store data in an approved off-site location approved by the state. The MCE must maintain or otherwise arrange for an alternate site for its system operations in a catastrophe or other serious disaster.

The MCE must take the steps necessary to recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The state and the MCE jointly determine when unscheduled system downtime is elevated to disaster status. Disasters may include natural disasters, human error, computer virus, or malfunctioning hardware or electrical supply.

The MCE must notify the state, at minimum, within two hours of discovery of a disaster or other disruptions in its normal business operations. Such notification must 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 MCE's capability to interface with the state or the state's contractors. Depending on the anticipated length of disruption, the state, at its discretion, may require the MCE to provide the state with a detailed plan for resuming operations. In case 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 MCE must resume normal business functions at the earliest possible time, not to exceed 30 calendar days. If deemed appropriate by the state, the MCE must coordinate with the state fiscal agent to restore the processing of claims by *Core* Medicaid Management Information System (*Core*MMIS), as applicable) if the claims processing capacity cannot be restored within the MCE's system. In case of other disasters or system unavailability caused by the failure of systems and technologies within the MCE's span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment, or electrical supply), the MCE must resume normal business functioning at the earliest possible time, not to exceed 10 calendar days.

The MCE's 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 daily and weekly backup that is adequate and secure for all computer software and operating programs; database tables; files; and system, operations, and user documentation.
- Demonstrating an ability to meet backup requirements by submitting and maintaining a *Disaster Recovery Plan* that addresses:
  - Checkpoint and restart capabilities
  - Retention and storage of backup files and software
  - Hardware backup for the servers
  - Hardware backup for data entry equipment
  - Network backup for telecommunications
- Coordinating required system operations with the state and its contractors, including backups of information sent or accepted, to ensure continuous eligibility, enrollment, and delivery of services.
- Providing the state with annually updated business resumption documents, such as:
  - Disaster recovery plans
  - Business continuity and contingency plans
  - Facility plans
  - Other related documents as identified by the state

11.2 Member Enrollment, Capitation, and POWER Account Data Exchange

The MCE is required to accept enrollment data in the HIPAA-compliant 834 electronic format. See the *834 MCE Benefit Enrollment and Maintenance Transaction* companion guide maintained by the state fiscal agent for details on the enrollment data exchanges specific to those programs. The MCE is responsible for loading the eligibility information into its claims system within five calendar days of receipt. The state fiscal agent produces enrollment roster change records seven days per week. Audit files for HIP and hospital PE generate on the first day of each month. Audit files provide a snapshot of the plans' enrollment for a given report date, whereas the change records provide daily updates to member enrollment. MCEs are notified via email if there are systematic delays with the enrollment roster reporting. Emails generate to the same email addresses that receive the file transfer notices.

The MCE is required to accept capitation and state Personal Wellness and Responsibility (POWER) Account payment data in the HIPAA-compliant 820 electronic premium payment format. See the *820 MCE Capitation Payment Information Transaction companion guide* for program-specific payment details. Capitation and state POWER Account cycles run monthly for HIP. The HIP financial cycle for per member per month (PMPM) capitation payments begins the third Wednesday of each month, producing 820 detail reports on the following Saturday. Funds are then transferred via electronic funds transfer (EFT) to the MCE the middle of the following week after 820s are produced.

The HIP 820 also encompasses capitation adjustments. 820s are produced the subsequent Saturday, followed by the EFT by the middle of the next week. HIP PMPM capitation, state POWER Account payments, and any capitation or POWER Account adjustments are all included in the 820 process.

If recoupment adjustment dollar amounts exceed payments for a given cycle, any unfunded recoupments are stored until the next applicable financial cycle. For example, if HIP capitation rate adjustments result in a greater dollar amount of recoupments than routine per-member, per-month payments, outgoing payments will not generate until all the recoupments have been satisfied. Also note that HIP has two independent financial cycles for capitation and POWER Account payments. If, for example, PRF recoupments exceed state POWER Account payments, no state POWER Account dollars generate until all the recoupments have been satisfied. HIP capitation payments are not affected.

Capitation is always driven by MCE and PMP assignments. MCEs receive full- or half-month capitation for HIP depending on the number of days a member is assigned to an MCE for a given month. Full-month capitation is paid for 18 total days or more of a member's assignment to the MCE. Half-month capitation is paid for 17 days or fewer. Days do not have to be consecutive, preventing multiple half-month capitation payments if a member has multiple assignments to an MCE in a given month. For example, if a member loses eligibility, then immediately regains eligibility, an assignment of 17 days or less results in a half-month capitation payment. The full-month rate is divided by two for the half-month rate. Capitation is not prorated by the exact number of days assigned.

The MCE is responsible for verifying member eligibility and receipt of capitation and state POWER Account payments for each eligible member. The MCE must reconcile its eligibility and payment records monthly for HIP. If the MCE discovers a discrepancy in eligibility, capitation, or state POWER Account information, the MCE must notify the state and the state fiscal agent within 30 calendar days of discovering the discrepancy and no more than 90 calendar days after the state delivers the eligibility records. The MCE must return any capitation or POWER Account overpayments to the state within 45 calendar days of discovering the discrepancy. If the MCE receives enrollment information or capitation, and/or the state's POWER Account contribution for a HIP member, the MCE is financially responsible for the member.

Enrollment may change at any time. For example, a HIP member who is enrolled with an MCE on the 18th day of the month for an effective date on the first of the following month will appear on the MCE enrollment roster produced on or around the 18th. If the member loses eligibility before the eligibility can take effect, the deletion is reported on or around the same date the eligibility loss is reported to *Core*MMIS from Indiana Eligibility Determination Services System (IEDSS). Deleted records include an INS03 segment of 024.

11.2.1 Capitation Adjustments – Systematic

Capitation payments are subject to change even after they have been paid to the MCE. Most are performed systematically as in the case of retroactive capitation rates. The state may retroactively reset capitation rates for the MCEs. The state sends written notification to the fiscal agent's Care Program operations manager. The notification includes the capitation categories, time period, newly calculated rate, and the affected MCE/region.

The state fiscal agent processes the rate changes in *Core*MMIS. The systematic capitation reconciliation process then determines affected prior payments and creates recoupment adjustments. The corresponding payment adjustment is also created. All recoupment and payment adjustments are noted by reason codes that distinguish adjustment details from regular per member per month details in the MCE's 820s. See applicable program capitation adjustment reason codes in *Appendix A*.

Capitation adjustments can also occur for eligibility-based scenarios:

- Member date of death reported retroactively (IEDSS)
- Member date of birth corrections (IEDSS)
- Retroactive member eligibility changes (aid category, level of care, benefit package)
- Retroactive MCE assignment changes

11.2.2 Capitation Adjustments – Manual

Manual adjustments to monthly capitation payments are performed by the fiscal agent as required.

Manual adjustments are placed on *hold* status in *Core*MMIS until reviewed and approved by the fiscal agent. Approved manual adjustments are activated before the capitation cycle.

11.3 POWER Account Systems

The MCE must have an information system that is capable of automating the required POWER Account transactions, including the 820, 834, and POWER Account Reconciliation File (PRF) transactions, in compliance with the data specifications set forth in the state fiscal agent's companion guides. The MCE must provide real-time access to member POWER Account balances in a secure format.

The MCE must have policies, procedures, and mechanisms in place to support the POWER Account requirements set forth in this manual and the state fiscal agent's companion guides. The MCE must have policies, procedures, and mechanisms in place to support accuracy, security, and privacy in the MCE's administration of member POWER Accounts.

Supplemental HIP report definitions and layouts created to assist the MCEs with maintenance of the HIP program are included in *Appendix E: Report Definitions for Fiscal-Agent Generated Reports*. These are primarily member eligibility reports designed to help the MCEs reconcile member enrollment and POWER Account data in their systems.

11.4 IHCP Fee Schedule Information

The Indiana Health Coverage Programs (IHCP) fee schedule information provides information about all Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and American Dental Association (ADA) procedure codes that are currently recognized by the IHCP. The information provided on the IHCP fee schedule reflects the most current allowed rate for all procedure codes pertinent to *CMS-1500*, 837 professional, and dental billers. The IHCP fee schedule contains the following information:

- Procedure code and description
- Modifiers
- Service category and description
- Program prior authorization (PA) indicator
- Attachment required indicator
- Rate type
- Pricing Method
- Rate effective date
- Rate end date
- Fee schedule amount
- Anesthesia base units, if applicable
- Min/Max Age
- Min/Max Units
- CMS Add Date/Termination Date

The IHCP fee schedule also contains ambulatory surgical center (ASC) rates that are used for paying outpatient surgery claims. The rates associated with each of the ASCs, along with specific ASC assignments by procedure code, are on the fee schedule. The fee schedule can be accessed using the quick links section at https://www.in.gov/medicaid/providers/.

11.4.1 Supplemental IHCP Rate Information

MCEs also have access to the following supplemental IHCP rate information through File Exchange. As rates change, the historical rate segments are maintained for rate files available through File Exchange. Rate updates occur with the monthly IHCP fee schedule update.

Supplemental rate information for inpatient pricing includes the following:

- Diagnosis-related group (DRG) base rates (universal base rates and provider specific base rates), weights and average lengths of stay
- Provider-specific rates apply to certain children's hospitals
- Capital cost per diem for calculating capital cost payment for hospital inpatient claims
- Provider-specific medical education rates to calculate the medical education payment for hospital inpatient claims
- Medical education payments are given for hospitals that are classified as teaching facilities.
- Inpatient level-of-care rates including psychiatric, burn, and rehabilitation per diems.
- Provider-specific inpatient level-of-care rates including psychiatric, burn, and long-term acute care per diems
- Provider-specific cost-to-charge ratios used to calculate cost outlier payments for hospital inpatient claims
- Marginal cost factor percentage used to calculate cost outlier payments for hospital inpatient claims
- Cost outlier threshold used to calculate cost outlier payments for hospital inpatient claims
- Revenue flat-fee rates associated with treatment room revenue codes, add-on revenue codes, and stand-alone revenue codes for payment of outpatient claims
- Maximum fee rates for technical component (modifier TC) of radiology services provided in outpatient hospital settings
- Lab fee rates that are used in payment of laboratory services performed in outpatient hospital settings
- Maximum fee rates for chemotherapy administration in outpatient hospital settings
- The supplemental IHCP rate information will also include nursing facility level-of-care rates used for reimbursement of long-term care claims.

11.5 Claims Processing

The MCE must have policies and procedures to audit and monitor providers' encounter claim submissions for accuracy, completeness, and timeliness of claims information. The MCE must have policies and procedures regarding claims submissions and processing that integrate with and support the internal quality management and improvement plan.

11.5.1 Claim Processing Capability

The MCE must demonstrate and maintain the capability to process and pay provider claims for services rendered to the MCE's members, in compliance with HIPAA, including NPI. The MCE must be able to price specific procedures or encounters (depending on the agreement between the providers and the MCE) and to maintain detailed records of remittances to providers. The state must preapprove the MCE's delegation of any claims processing function to a subcontractor, and the MCE must notify the state and secure the state's approval of any change to subcontracting arrangements for claims processing.

The MCE must develop policies and procedures to monitor claims adjudication accuracy and must submit its policies and procedures for monitoring its claims adjudication accuracy to the state for review and approval. The MCE must also submit its policies and procedures for monitoring its claims adjudication accuracy against its own internal criteria. The state recommends that the MCE's standards for accuracy of internal claims processing and financial accuracy be no less than 95%.

The out-of-network provider filing limit for submission of claims to the MCE is 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 MCE's provider agreements pursuant to the guidelines set forth in Section 8.4 in the Scope of Work, which generally require in-network providers to submit claims within 90 calendar days from the date of service. MCEs have up to 15 months from the date of service to submit encounter data to the fiscal agent. Voids and replacements of previously paid encounter claims can be submitted up to two years from the "to" date of service on the claim.

The MCE must 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 noncontracted providers outlined in *405 IAC 1-1.6-1*.

11.5.2 Compliance with State and Federal Claims Processing Regulations

The MCE must also comply with state and federal claims processing regulations such as the following:

- The MCE must have a claims processing system to support electronic claims submission for in- and out-of-network providers.
- The MCE's system must process all claim types, such as professional and institutional.
- The MCE must comply with 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.
- The MCE must ensure that communication with providers, particularly out-of-network providers, and submission requirements are efficient and not burdensome for providers.
- The MCE is prohibited from requiring out-of-network providers to establish an MCE-specific provider number to receive payment for claims submitted.

11.5.3 Claims Payment Timelines

The MCE must pay or deny electronically filed clean claims within 21 calendar days of receipt. (As set forth in *IC 12-15-13.1.6*, a *clean claim* is one in which all information required for processing the claim is on the claim form.) The MCE must pay or deny clean paper claims within 30 calendar days of receipt. If the MCE fails to pay or deny a clean claim within these time frames and subsequently reimburses for any services itemized within the claim, the MCE must also pay the provider interest, as required under *IC 12-15-21-3*. The MCE must pay interest on all clean claims paid late (for example, in- or out-of-network claims) for which the MCE is responsible, unless the MCE and provider have made alternate written payment arrangements. The state reserves the right to perform a random-sample audit of all claims, and expects the audited MCE to fully comply with the requirements of the audit by providing all requested documentation, including provider claims and encounters submissions.

11.5.4 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 MCE 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 the Indiana.

New, revised, or deleted Medicaid NCCI edits shall not be published or otherwise shared by the MCE 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 MCE. 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.

11.5.5 Encounter Data Submission

The MCE must have policies, procedures, and mechanisms in place to support the following encounter data reporting process and in the state fiscal agent's companion guides. MCEs must strictly adhere to the standards set forth in the state fiscal agent's companion guides for professional and institutional claims, such as the file structure and content definitions (including any content definitions as may further be interpreted or defined by the state).

The MCE must 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 must be included on all encounter claims. The MCE's encounter claims must 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 (for example, original, void, or replacement) is also required, in the form designated by the state fiscal agent. The amount of POWER Account funds used to pay the claim must be designated on each encounter claim.

The MCE must submit an encounter claim to the state fiscal agent for every service rendered to a member for which the MCE either paid or denied reimbursement. Encounter data provides reports of individual patient encounters with the MCE's healthcare 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. See applicable sections for claims compliance and qualitative analysis.

Information about compliance with encounter claim submission follows. Payment of liquidated damages does not relieve the MCE of its responsibility to provide complete and accurate encounter claims as required under the contract.

11.5.6 Weekly Batch Submission

The MCE must submit via secure FTP at least one batch of encounter claims before 5 p.m. on Wednesday of each week, for paid and denied institutional, pharmacy, and professional claims, in accordance with the terms of the contract and scope of work. If, during any calendar month, the MCE fails to submit all encounter claims on a weekly basis when due, unless the delay is caused by technical difficulties of the office, the MCE pays liquidated damages in the amount of $4,850 for each claim type for which shadow and encounter claims were not submitted in a timely manner.

11.5.7 Pre-Cycle Edits

For each weekly encounter claim batch submission, the MCE must achieve no less than a 98% compliance rate with pre-cycle edits. The state assesses pre-cycle edit compliance based on the average compliance rate of the weekly encounter claims batch submissions made during the calendar month. If the average compliance rate is less than 98%, the MCE pays liquidated damages in the amount of $4,850 per each claim type.

The MCE Technical Meeting provides a forum for MCE 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 MCE must report any problems it is experiencing with encounter data submissions and reporting at this monthly meeting and to its designated state contract compliance analyst.

The state will use the encounter data to make tactical and strategic decisions related to the HIP program, including primarily using encounter data to calculate MCE's future capitation rates. It will also use encounter data to calculate incentive payments to the MCE, monitor quality, and assess the MCE's contract compliance.

Additional requirements for encounter claims include the following:

- Timeliness of Encounter Claims Submission to the state Fiscal Agent – MCEs must submit all encounter claims within 15 months of the earliest date of service on the claim. In addition, MCEs must submit 98% of adjudicated claims within 21 calendar days of adjudication. The state will require the MCE to submit a corrective action plan to address timeliness issues and will assess liquidated damages if the MCE fails to comply with pre-cycle edits.
- Compliance with Pre-Cycle Edits – The state fiscal agent will assess each encounter claim for compliance with pre-cycle edits. The MCE must correct and resubmit any encounter claims that do not pass the pre-cycle edits. The state will require MCEs to submit a corrective action plan to address noncompliance issues and will assess liquidated damages if the MCE fails to comply with pre-cycle edits.
- Accuracy of Encounter Claims Detail – MCEs must demonstrate that it implements policies and procedures to ensure that encounter claims represent the services provided and that the claims are accurately adjudicated according to the MCE's internal standards and all state and federal requirements. The state reserves the right to monitor encounter claims for accuracy against the MCE's internal criteria and its level of adjudication accuracy. The state will regularly monitor accuracy by reviewing the MCE's compliance with its internal policies and procedures for ensuring accurate encounter claims submissions and by performing a random sample audit of all claims. The state expects MCEs 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. The state will require MCEs to submit a corrective action plan to address noncompliance issues and will assess liquidated damages if the MCE fails to comply with encounter claims accuracy reporting standards.
- Completeness of Encounter Claims Data – MCEs must have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers. For example, for every service provided, providers must submit corresponding claim or encounter data with claim detail

identical to that required for fee-for-service claims submissions. MCEs must 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.

- Pharmacy Encounter Claims – To facilitate the state's collection of Medicaid drug rebates, the MCE must submit pharmacy encounter data to the state in a timely, accurate, and complete manner. At minimum, the following information must be provided: (i) the total number of units of each dosage form; (ii) strength and package size by National Drug Code (NDC) of each covered outpatient drug dispensed to MCE members; and (iii) such other data that the Secretary of CMS determines necessary for the state to access rebates. If the MCE fails to provide required files for drug rebate purposes in a timely, accurate, and complete manner, the MCE shall be responsible for the loss of the rebate money and/or interest entitled to the state.

The MCE 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.

11.5.8 Encounter Data Considerations

HIP MCEs currently submit encounter data to the fiscal agent. After pre-cycle edits, the encounter submissions are processed through *Core*MMIS back-end edits and audits, and finally stored on data tables that are then transmitted to the Electronic Data Warehouse.

11.5.9 Coordination of Benefits (COB) Details

- MCEs must follow the 837 COB format and include their encounter data in the coordination of benefits (COB) loops of the transaction.
- MCEs format the 837 with their payment information in the first iteration of the COB loops before submitting encounter data.
- Encounter data is accepted only from MCEs and rejected from all others.
- MCEs send only claims that have been paid or denied at the claim and detail level in their systems.
- MCEs exclude claims that have not been finalized in their systems.

11.5.10 Encounters for Units of Service over 9999

*Core*MMIS is limited to 9999 units of service on the front-end processing. If a service is billed at the header level with units over the 9999 limitation, the encounter will reject. To bypass the front-end processing, the MCEs are required to submit encounters with the multiple details lines to break out the units under the 9999 limitation. The encounter is accepted into *Core*MMIS for back-end processing and available for reporting purposes. An example of this type of encounter would be for services related to blood factors.

11.5.11 Encounters Voids for Services Payable as FFS

The state fiscal agent redirects providers to the MCEs when providers are having claims deny because of duplicate encounters for FFS-payable services that are less than two years old. MCEs must then void the encounter claims so that providers can resubmit the services as FFS and bypass the duplicate claims editing.

For services more than two years old, the fiscal agent's Provider Relations team will work with the provider and the MCE to verify common agreement that the claim, indeed, needs to be voided. After all parties agree, the Client Services team will submit a special batch request to the state Care Programs and

Claims teams for their approval. The provider is notified after the approval is obtained, the void is completed, and the special batch claim is processed.

11.5.12 Fully Denied Claims

Claims submitted as encounter data are those claims that the MCE has accepted for payment. If the MCE has a claim that contains denied and paid details, the claim is submitted as a paid encounter. MCEs must submit encounter data to report services rendered within the health plan that were included in the capitation paid to a particular provider.

MCEs are required to submit monthly data files of the denied professional and institutional HIP encounter data to the state fiscal agent. MCEs are allowed to submit the denied encounters in their regular encounter files and the monthly denied encounter filing limit still applies.

HIP fully denied professional and institutional encounter claims are indicated in the 837 transaction at the detail only:

- All claim details contain SVD02 = 0 and CAS02 = ARC code requested by MCE to identify their MCE denied details.

The fully denied encounter claims are processed through the front end (EDI) editing bypassing the MCE ARC logic and applied edit 292. The denied encounter data is stored in a separate table with Claim ID beginning with 24 and is not viewable in *Core*MMIS. The denied encounter data is used by the state for reporting purposes. The fiscal agent will not process these claims through *Core*MMIS and will not be applying the back end claim edits and audits.

11.5.13 Denied Encounters and Rejected Common Definitions

Rejected claims must not be submitted as encounter data. A rejected claim is a claim that the MCE cannot accept into its inventory for future adjudication. Rejected claims include:

- Misdirected claims: A claim submitted to the wrong entity for processing (for example, claim submitted to the wrong MCE).
- Claims for members not currently enrolled.
- Claims for which the MCE or Managed Behavioral Healthcare Organization (MBHO) is not financially responsible (for example, a provider submits a claim to the MCE for an MBHO covered service).
- Unclean claims (a claim in which all the information required for processing is not present – per *IC 12-15-13.0.6*).

Claims that were rejected or claims that were received and denied by the MCE because they did not pass HIPAA compliance edits, must not be submitted as encounters. These rejected claims correlate with the fiscal agent's electronic data interchange (EDI) Edit #132 (non-HIPAA compliant transaction). They will not pass the fiscal agent's pre-cycle edits. The MCE must conduct provider outreach and education to assist the provider with resubmitting a corrected claim to secure payment. Therefore, this subsequent submission would be available for utilization data as either a paid encounter or denied encounter from resubmission.

Denied encounters include all clean claims that do not fall into one of the aforementioned categories and must be submitted as encounter data. This includes all clean paid claims (partially paid and fully paid) and all clean fully denied claims. A clean claim is a claim submitted by a provider for payment that can be adjudicated without obtaining additional information from the provider of the service or a third party.

11.5.14 HIPAA Adjustment Reason Codes

The MCE Adjustment Reason Codes (ARCs) are used for denied details in the paid encounter processing. Each MCE is required to maintain and provide its applicable ARCs to the state fiscal agent. The MCE's ARCs are used in the encounter claim processing at the detail level.

The fiscal agent EDI Solutions Unit coordinates with the MCEs and the fiscal agent Systems Unit to incorporate the new ARC into the MCE's ARC tables. EDI sends an *ARC Code Update* form to the MCEs one week before January, April, July, and October. Each MCE completes the form, listing new ARC codes to indicate denied details for the encounter claim processing. The MCE can also designate if no updates. Email notification is sent to the fiscal agent EDI team.

ARC update forms must be emailed by the 10th of each month listed previously to the following address: INXIXElectronicSolution@gainwelltechnologies.com

11.5.15 Encounter Data Output Documents

*Core*MMIS acknowledges each encounter submitted by the MCE. This acknowledgment includes the *Submission Summary Report*, an electronic Remittance Advice (RA) and the *835 Remittance Advice Transaction.*

11.5.15.1 Encounter Submission Summary Report

The *Encounter Submission Summary Report (ESSR)* shows claims accepted in *Core*MMIS for processing in addition to claims rejected in the pre-cycle editing process. Error code descriptions are in the *835 Health Care Claim Payment/Advice Transaction* companion guide. The *ESSR* is generated by the Enterprise Data Warehouse every Tuesday at 5:00pm EST and posted to the state SFTP site. The *ESSR* is the basis for the application of liquidated damages that may be applied, at the discretion of the state, if the acceptance rate falls below 98% for any single batch submission.

11.5.15.2 Remittance Advice

The 835 electronic remittance advice (RA) is generated for all claims accepted and adjudicated in *Core*MMIS. Because encounter data is adjudicated with either a paid or denied disposition, the RA for these claims indicates the disposition.

The 835 is posted after the financial cycle is completed on the weekend, acknowledging the claims processed during the previous week's claim cycle. It is then available on the File Exchange server or the dial-up server (depending upon how the trading partner is set up).

The 835s remain on the File Exchange server for 30 days unless the trading partner deletes them. It is very important that the plans download files in a timely manner. The files remain on the dial-up server until the trading partner downloads are complete. The cut-off time for claims to be included in the weekly financial cycle is Wednesday at 4 p.m.

The fiscal agent business objects reporting unit supplies the MCEs a weekly 835 supplemental file that provides detail descriptions of the back end edits that were applied to the adjudicated MCE's paid and denied encounters. This file helps the MCEs reconcile their encounter claims errors.

11.5.16 Encounter Data Corrections and Resubmissions

MCEs must have a procedure in place to review the *Submission Summary Reports* and RA files previously described to identify claims denied in either the precycle or adjudication processes. The *Submission*

Summary Reports references error codes contained in the *835 Health Care Claim Payment/Advice Transaction*. The MCE may resubmit the corrected claim in the next batch submission.

CMS-1500 or 837P claims containing paid and denied details may be completely resubmitted or denied details only resubmitted. Resubmitted details on claims that adjudicated with a paid status deny as duplicates on the resubmission.

UB-04 or 837I claims are not adjudicated at the detail level, so denied elements must be corrected and the entire claim resubmitted.

ADA 2012 claim form and 837D transaction are used for dental claims same as above.

MCEs may bring questions about any aspects of encounter data submission and adjudication to the monthly MCE Technical Meeting.

11.6 Third-Party Liability

If a member is also covered by another insurer, the MCE is fully responsible for coordinating benefits so as to maximize the utilization of third-party coverage. The MCE must share information regarding its members, especially those with special healthcare needs, with other payers as specified by the state and in accordance with *42 CFR 438.208(b)*. In the process of coordinating care, the MCE must protect each member's privacy in accordance with the confidentiality requirements stated in *45 CFR 160* and *164*. The MCE is responsible for payment of the member's coinsurance, deductibles, copayments and other cost-sharing expenses, but the MCE's total liability must not exceed what the MCE would have paid in the absence of third-party liability (TPL), after subtracting the amount paid by the primary payer.

The MCE must coordinate benefits and payments with the other insurer for services authorized by the MCE, but provided outside the MCE's plan. Such authorization may occur before provision of service, but any authorization requirements imposed on the member or provider of service by the MCE must not prevent or unduly delay a member from receiving medically necessary services. The MCE remains responsible for the costs incurred by the member with respect to care and services, which are included in the MCE's capitation rate, but which are not covered or payable under the other insurer's plan.

An MCE 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.

11.6.1 Third-Party Liability Coordination of Benefits

Coordination of benefits is covered for many of the MCE members. Each aid category must be treated appropriately in accordance with the state policy. Each MCE must have policies and procedures in place to ensure the appropriate application when coordinating benefits for its members.

If the HIP member primary insurer is a commercial health maintenance organization (HMO) and the MCE cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the MCE's rules, the MCE may submit to the enrollment broker a written request for disenrollment. The request must provide the specific description of the conflicts and explain why benefits cannot be coordinated. The enrollment broker will consult with the state and the request for disenrollment is considered and acted upon accordingly.

11.6.2 Third-Party Liability Data Sources

The state fiscal agent provides each MCE with a monthly list of known TPL resources for its enrolled HIP members. The jobs that create the MCE TPL files run on the evening of the 20th of every month. The files

are available for download from the File Exchange during the early morning hours of the 21st of each month. The TPL file layout is being expanded to include TPL-source code information. The TPL file layout is available on the *MCE Secure Landing* page at in.gov/medicaid/partners.

Medicare information is also provided to the MCEs for HIP members who have overlapping Medicare. The Medicare extract file layout is available on the *MCE Secure Landing* page at in.gov/medicaid/partners. The extract runs monthly and is posted to File Exchange monthly.

The data on the monthly TPL file and TPL information accessed via the automated eligibility systems IVR, 270/271 transaction, and the Portal are limited to the most current information on file with the fiscal agent.

The fiscal agent obtains TPL information for members from several sources, including the following:

- DFR/IEDSS
- HMS, the fiscal agent's subcontractor
- Providers
- Members

The fiscal agent verifies the TPL information received from providers and members. Health Management Systems (HMS) verifies its data before sending it to the fiscal agent and the TPL data from IEDSS is not independently verified by the fiscal agent. Any TPL information found for members can be submitted to the fiscal agent using either the *Medicaid Third Party Liability Questionnaire* or the *Provider TPL Referral Form*. The completed form is mailed to the following address:

Gainwell TPL/Casualty Unit
P.O. Box 7262
Indianapolis, IN 46207-7262

The completed form may also be faxed to 866-667-6579. TPL information can also be submitted via the Portal > Eligibility inquiry by selecting *TPL Form*.

11.6.3 Managed Care Entity Third Party Liability Responsibilities – Cost Avoidance and Coordination of Benefits

When the MCE is aware of health or casualty insurance coverage, before paying for a healthcare service for a member, the MCE can reject a provider's claim and direct that the claim be submitted first to the appropriate third party.

When the MCE becomes aware that an enrollee has instituted a legal cause of action for damages against a third party, the MCE sends written notification to the fiscal agent that includes the following:

- Enrollee's name
- IHCP Member ID
- Date of accident or incident
- Nature of injury
- Name and address of enrollee's legal representative

The MCE also provides the fiscal agent with copies of pleadings and any other documents in its possession related to the action.

If insurance coverage is not available, or if one of the exceptions to the cost-avoidance rule applies, then payment must be made and a claim made against the third party, if it is determined that the third party is or may be liable.

The MCE must ensure that its cost-avoidance efforts do not prevent an enrollee from receiving medically necessary services in a timely manner.

11.6.4 Cost Avoidance Exceptions

Cost avoidance exceptions in accordance with *42 CFR 433.139* include the following situations in which MCEs must 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 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 (for example, the MCE was not aware of the third-party coverage); the MCE must pursue reimbursement from potentially liable third parties.

11.6.5 Third-Party Liability Collection and Reporting

As an incentive to identify TPL and coordinate benefits, the MCE may retain a portion of TPL collections for their members. TPL collections must be reported in accordance with reporting requirements outlined in the *MCE Reporting Manual*. In accordance with *IC 12-15-8* and *405 IAC 1-1-15*, the state 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. MCEs 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. The MCE may retain all TPL collections received on behalf of its HIP members.

11.7 Health Information Technology and Data Sharing

The MCE must develop, implement, and participate in healthcare information technology (HIT) and data-sharing initiatives to improve the quality, efficiency, and safety of healthcare in Indiana. The MCE must also cooperate and participate in the development and implementation of future state-driven HIT initiatives. The state's requirements for HIT and data sharing vary by resources available in each region.

MCEs are required to enter into data-sharing agreements with any health information technology entity that the state enters into data-sharing agreements with.

The state reserves the right to require MCEs to establish personal health records (PHRs) for its members in the future. A PHR is an electronic health record of the member that is maintained by the MCE. PHRs typically include a summary of member health and medical history such as diagnoses, allergies, family history, lab results, vaccinations, surgeries, and so forth, and may also include claims information. If the state adopts a standard PHR format, the MCE is required to implement the state's standard format. The MCE is also required to incorporate its member portal information and POWER Account balance information into the PHR.

In addition to a PHR, the following are examples of HIT initiatives the MCE must consider developing:

- Electronic medical record (EMR) – An electronic medical record provides for electronic entry and storage of patients' medical record data. Depending on the local information technology infrastructure,

EMRs may also allow for electronic data transmission and data sharing. More complex EMRs can integrate computerized provider order entry and e-prescribing functions.

- 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.
- 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.
- Benchmarking – Insurers 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 insurers and providers to help them identify opportunities for improvement or can be linked to pay for performance initiatives.
- Telemedicine – Telemedicine 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 telemedicine to consult with each other and share their expertise for the benefit of treating complex patients. Insurers are encouraged to develop reimbursement mechanisms to encourage appropriate use of telemedicine.
- Mobile and Self-Service Technology – The MCE is encouraged to use 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 MCE and/or physician practices and medication and appointment reminders through personalized voice or text messages.

To ensure interoperability among providers (including laboratory, pharmacy, radiology, inpatient hospital/surgery center, outpatient clinical care, home health, public health, and other providers), organizations at the national level, including the Health IT Standards Panel and the Certification Commission for Health IT, are working to develop standards. The MCE is encouraged to use these standards in developing its electronic data sharing initiatives, if any. These standards relate to:

- IT architecture
- Messaging
- Coding
- Privacy/security
- A certification process for technologies

Currently, resources and infrastructure for HIT vary widely throughout Indiana. There are multiple strategies and tactics that MCEs can adopt to participate directly and to incent providers to participate in HIT. Some examples include:

- Contract or affiliate with existing health information exchanges and information networks
- Develop coalitions with other healthcare providers to develop health information exchanges and information networks
- Develop proposals for health information exchanges and information networks, and apply for grants to support those proposals
- Require providers to participate in one of Indiana's established health data exchanges or information networks, in regions where those networks are currently established
- Require high-volume prescribers to use some level of e-prescribing

- Require high-volume providers to use EMRs
- Identify providers that are and are not currently participating in information networks or using EMRs, e-prescribing, CPOE, or other HIT to focus incentives

Offer incentives to providers for adopting HIT, such as providing free or subsidized handheld devices to physicians for electronic prescribing, and/or providing financial or nonfinancial incentives to providers that adopt EMRs or electronic prescribing.

Section 12: Performance Reporting and Incentives

Plans must submit required performance data in the form and manner specified by the state and consistent with the requirements of the *MCE Reporting Manual,* and in accordance to the terms of the managed care entity's (MCE's) contract with the state. Plans must have policies, procedures, and validation mechanisms in place to ensure that the financial and nonfinancial performance data submitted to the state and/or its subcontractors is accurate. Reports must be submitted under the signature of the plans' financial officer or executive leadership (for example, president, chief executive officer, executive director), certifying the accuracy, truthfulness, and completeness of the data.

The required reports, format, and reporting calendar is produced by the state on an annual basis and compiled in the *MCE Reporting Manual.* However, the state may modify the frequency of reports and may require additional recurring reports with reasonable advance notice to the plans. For purposes of this policy, *reasonable advance notice* is defined as at least 30-calendar-days' notice.

Performance reports must be submitted in the format specified by the state, using the most current version of supplied Report Templates, if applicable. Reports may be required for major subcontracted entities and/or separately by program. It is the responsibility of the plan to accurately, completely, and timely report all delegated performance data.

Reports may be due on an annual, semiannual, quarterly, monthly, or ad-hoc basis. Plans must submit performance reports by the dates due as indicated in the *MCE Reporting Manual* (or similar document), issued by the state each year. Plans must submit all performance reporting data electronically to the state's reporting SharePoint site in the appropriate folders by the due date in the format and naming conventions described in the *MCE Reporting Manual*. Plans may submit performance data earlier than the actual date the data is due. However, the state considers the performance data late if the state does not receive the performance data electronically in the designated location by 4 p.m. (Indianapolis time) on the date due. If the deadline falls on the weekend, it is due the first business day following the deadline.

Plans may occasionally encounter internal operational issues that prevent timely submissions of performance data. The state considers a plan's request for a submission extension under the following conditions.

- The plan must submit its request for an extension at least one full business day before the data is due to the state.
- The plan must submit the request in writing via email directly to its assigned state contract manager and the quality program evaluation manager with a carbon copy to the contract compliance officer.
- The plan's written request must be sent from the MCE compliance officer or the officer's alternate.
- The plan's written request must explain why an extension is necessary and must suggest an alternative submission due date for the state to consider.

The state responds with a decision to the plan's request via email. The state may consider the plan's reporting submission as untimely if the request does not follow the prescribed protocol. Further, extensions are granted solely at the state's discretion. If the extension request is denied, the state will consider the submission untimely if received past the due date.

Plans must submit complete and accurate data. However, if the plan discovers that it has omitted some performance data during a reporting cycle or discovers errors in data submitted to the state, the plan must notify its designated state contract manager upon discovery.

If the plan fails to provide performance data as required, the state may consider the plan noncompliant in its performance reporting and may assess liquidated damages or take corrective action as outlined in Exhibits 3 and 4 of the Scope of Work.

As required to meet the deliverables in the Scope of Work or as requested by the state, an MCE may be asked to submit ad hoc reports, data analysis, and/or material for the purpose of presentation to program stakeholders. If the state makes such a request, the MCE must submit such material within 30 calendar days or at an alternative date specified by the state (whichever comes sooner). The MCE must provide such reports to the state in the following format, unless directed otherwise by the state:

- Cover Page
  - MCE ID/Name
  - Program Name
  - Report Title
  - Report Description – The Report Description must outline its purpose, as well as what each of the rows and columns of the report represent; for example, a *key* as to how the report is to be read and interpreted
  - Data Period
  - Data Source
  - Date Run
- Table of Contents (if appropriate for content)
- Executive Summary – The Executive Summary must include, but is not limited to, a clear statement of the question at hand, the MCE's high-level analysis of the data, its key findings, a clear statement of its recommendations and/or any action items, and the MCE staff responsible for each action item. It must not exceed two pages in length.
- Component Reports as Directed by the state
- Definition of Terms/Terminology Used in the Report
- The report is to be paginated in a sequential fashion, beginning to end, first page to last, and the Table of Contents (if applicable) is to match exactly to the pagination. The overall appearance of the report (for example, orientation of information [landscape vs. portrait] as it appears on the pages, how the report is bound) is not to vary substantially from iteration to iteration unless approved by the state. Each individual component report must have identifying information located in the margin that is unique to each report.
- The report is to be provided in electronic and hard-copy format to the state.
- The electronic version of the report must be in a printer-friendly format requiring no manual manipulation to format print readiness.
- For presentations to stakeholders, the report must be the primary document to support the material presented and all attending MCE staff must be thoroughly conversant with the content of the entire report.
- The report must be submitted in the same font, preferably 12-point throughout.

The header and footer of the document must be defined across all pages of the report. The footer must include the MCE name, page number X of XX total pages, and date of the information. The title of the report must be included in the header or footer as appropriate for formatting of the document.

Section 13: Member Communication on Rollover and Application

Managed care entities (MCEs) are required to send letters notifying members that they have earned a refund, rollover, how it is applied and what to expect going forward in the program in terms of payments in the following months. MCEs need to send examples of the following items.

13.1 Letters

13. *HIP Plus* rollover applied to current *HIP Plus* member with and without state match
    - Explanation that after credit is used up, member will need to continue paying Personal Wellness and Responsibility (POWER) Account contribution (PAC)

14. *HIP Plus* rollover applied to current *HIP Basic* member with and without state match
    - Letter should indicate if *Basic* member has moved to *Plus* because of rollover or if they have a reduced required PAC and are not *Potential Plus*.
    - An explanation will also be needed that after credit is used up, member will need to continue paying PAC

15. *HIP Basic* rollover applied to current *HIP Basic* members
    - Version with only percent/dollar discount and version with member dollars and nonpayment penalty
    - Include explanation of *Potential Plus* where applicable
    - Amount of discount dollars applied to account going forward
    - For those with enough member dollars remaining for direct transfer to *HIP Plus*, provide explanation of *HIP Plus* transfer in addition to explanation that after the credit is used up member will need to pay PAC

16. *HIP Basic* rollover applied to current *HIP Plus* member
    - Version with only percent/dollar discount and version with member dollars and non-payment penalty
    - Explanation that discount is applied to entire current *HIP Plus* period (including previous months member was in *HIP Plus*) and is applicable for the rest of the benefit period as long as the member stays in *HIP Plus*
    - Amount of discount and amount of credit if any for PACs already paid in year, explanation that after the credit is used up that the member will need to continue paying PAC

17. Refunds
    - Letter should provide an explanation about why the funds are being refunded back to the member
    - Letter should provide the amount of the refund
    - Details explaining how the member can deposit their refund check

13.2 Invoices

- Invoices clearly showing the dollar discount for members that owe PAC and earned a dollar discount
- When member owes part of a PAC after having a credit applied, invoice clearly showing the remaining rollover credit applied to the account and the balance due.

13.3 POWER Account Statements

- Clearly showing any member or state dollar credits on the account and explaining they are because of rollover
- Application of rollover to a PAC should be applied and reflected on the next month's statement following the receipt of the POWER Account 820

13.4 Call Scripts Explaining Rollover to Members

- Provide script scenarios of what the MCE call center representatives are expected to say when asked questions about rollover.

Appendix A: Healthy Indiana Plan Code Tables

Monthly, the managed care entities (MCEs) access HIP capitation data using the *820 MCE Capitation Payment Information Transaction* companion guide. The following tables provide the codes applicable to the HIP 820 transaction file which are confirmed in the *820 MCE Capitation Payment Information Transaction* companion guide.

The following tables list the capitation rate cells, reason codes, and Personal Wellness and Responsibility (POWER) Account payment reason codes applicable to HIP. The HIP POWER Account process has only one category: PW.

Table 30 – HIP MCE Capitation Rate Cells

Description	Capitation Categories
Male State Plan Plus 19 – 24	S1
Male State Plan Plus 25 – 34	S2
Male State Plan Plus 35 – 44	S3
Male State Plan Plus 45 – 54	S4
Male State Plan Plus 55 – 64	S5
Male State Plan Basic 19 – 24	B1
Male State Plan Basic 25 – 34	B2
Male State Plan Basic 35 – 44	B3
Male State Plan Basic 45 – 54	B4
Male State Plan Basic 55 – 64	B5
Female State Plan Plus 19 – 24	S6
Female State Plan Plus 25 – 34	S7
Female State Plan Plus 35 – 44	S8
Female State Plan Plus 45 – 54	S9
Female State Plan Plus 55 – 64	SX
Female State Plan Basic 19 – 24	B6
Female State Plan Basic 25 – 34	B7
Female State Plan Basic 35 – 44	B8
Female State Plan Basic 45 – 54	B9
Female State Plan Basic 55 – 64	BX
Male State Plan Plus 19 – 24	P1
Male State Plan Plus 25 – 34	P2
Male State Plan Plus 35 – 44	P3
Male State Plan Plus 45 – 54	P4

Description	Capitation Categories
Male State Plan Plus 55 – 64	P5
Male State Plan Basic 19 – 24	R1
Male State Plan Basic 25 – 34	R2
Male State Plan Basic 35 – 44	R3
Male State Plan Basic 45 – 54	R4
Male State Plan Basic 55 – 64	R5
Female HIP Plan Plus 19 – 24	P6
Female HIP Plan Plus 25 – 34	P7
Female HIP Plan Plus 35 – 44	P8
Female HIP Plan Plus 45 – 54	P9
Female HIP Plan Plus 55 – 64	PX
Female HIP Plan Basic 19 – 24	R6
Female HIP Plan Basic 25 – 34	R7
Female HIP Plan Basic 35 – 44	R8
Female HIP Plan Basic 45 – 54	R9
Female HIP Plan Basic 55 – 64	RX
Medically Frail – Plus	FP
Medically Frail – Basic	FB
Pregnant Females – State Plan	PS
Pregnant Females – HIP	PR (Ended 1/31/2018.)
Case Rate – State Plan	DS
Case Rate – HIP	DR
Pregnant Female – MAMA	PM MAMA
Case Rate – MAMA	DM
Hospital Presumptive Eligibility	AP (Ended 12/31/2018.)

Table 31 – HIP Capitation Payment Reason Codes

Reason Code	Description
PN	Payment – Normal
PR	Payment – Retro
RD	Recoupment – Death
PT	Payment – Increase Adjustment
RT	Recoupment – Decrease Adjustment

Reason Code	Description
PU	Payment – Member Elig Adjustment
RU	Recoupment – Member Elig Adjustment
PV	Payment – Adjustment Auto Recon
RV	Recoupment – Adjustment Auto Recon Full
PW	Payment – Half Month Normal
RH	Recoupment – Adjustment Auto Recon Half
HN	Payment – Half Month Normal

Table 32 – POWER Account Payment Reason Codes

HIP Reason Code	Reason Code Description
MP	Member Penalty
RA	Recoupment - Adjustment Online
RM	Recoup - Rollover Member Amount
SC	State POWER Account
SR	Payment - State POWER Rollover to Receiving Plan
SS	Payment - Member POWER Rollover to Receiving Plan
TP	Termination Payment Due to Void Termination POWER Account Reconciliation Transaction
TR	Recoup - Termination
TU	True Up Amount
WR	State POWER Account Recoup

Appendix B: Subcontract Approval Checklist

This form is used when the managed care entity (MCE) chooses to subcontract a service to another vendor. This form must be completed and sent to the state for approval.

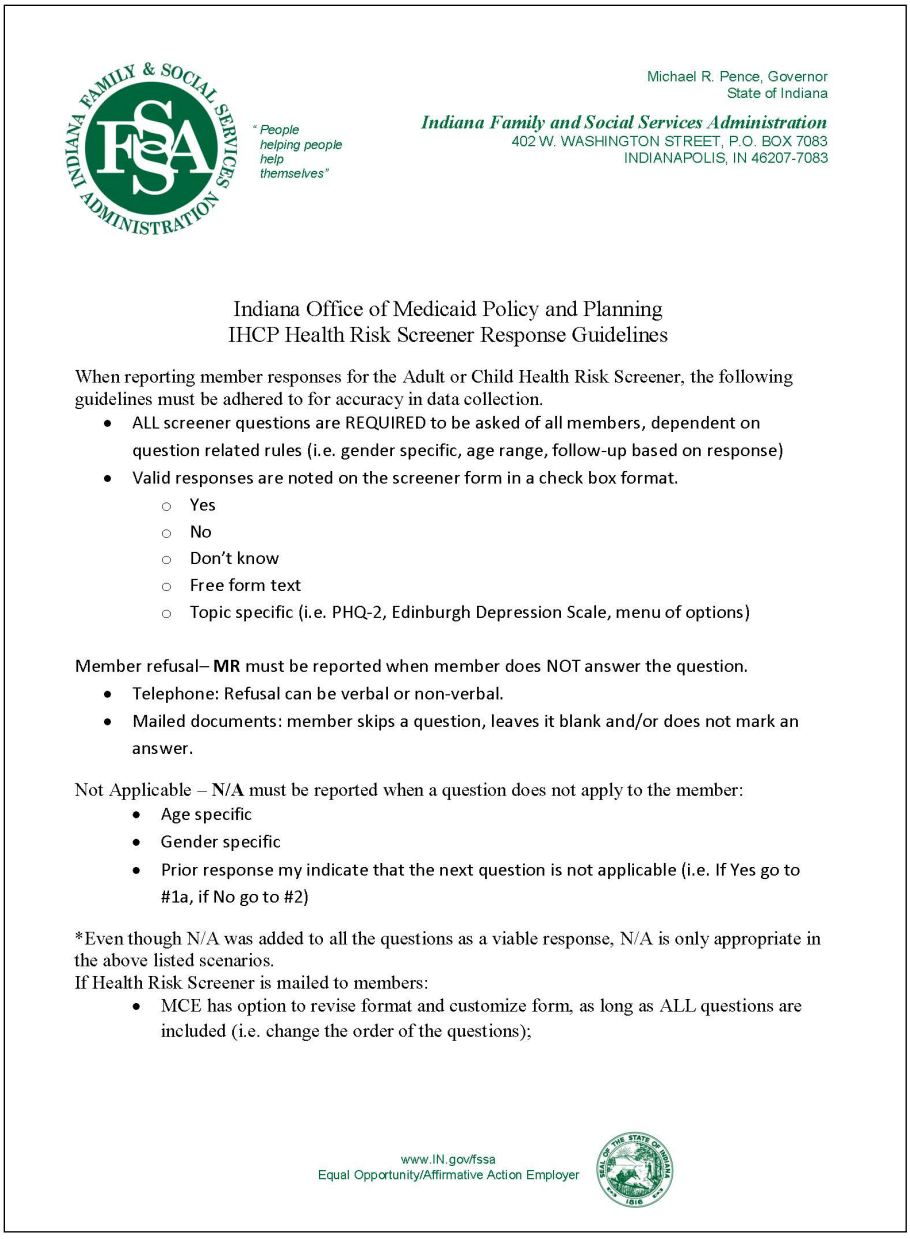
Figure 1 – Subcontract Approval Checklist

FOR OMPP REVIEW: MCE SUBCONTRACT CHECKLIST						
MCE Name:				Subcontract:		
MCE Contact:				Date to OMPP:		
OMPP Plan Contact:				Date returned to MCE:		
		MCE to complete		OMPP/Legal to complete		
	For any/every subcontract:	page #	paragraph	OK	Needs revision	Comments
1	Describes amount, duration and scope of services to be performed					
2	Describes monitoring and oversight procedures; provides option for revoking delegation or imposing other sanctions for inadequate performance					
3	Allows OMPP to evaluate, through inspection or other means, quality, appropriateness and timeliness of services performed					
4	Allows inspection of any records pertinent to the contract by state and federal officials					
5	Requires adequate record system for recording services, charges and dates, etc.for services rendered to members					
6	Allows participation in internal/external quality assurance, utlilization review, peer review and/or grievance procedures					
7	Indemnifies the State					
8	Identifies and incorporates the applicable terms of the State/MCE contract					
9	Term of contract does not extend beyond the State/MCE contract term					
	In addition, for any subcontractor rendering health care services:					
10	A written provider claim dispute resolution procedure					
	In addition, for all PMP agreements:					
11	Provision allowing PMP to terminate the agreement for any reason upon 90-day written notice to the MCE.					
	For all subcontracts which transfer >5% of MCE's financial risk to the subcontractor:					
12	Requires submission of quarterly and annual financial info					
Additional Notes/Comments:						

Appendix C: Health Risk Screener Response Guidelines

The following are guidelines to use when completing a health risk assessment. These guidelines help evaluate the answers given by the member or prospective member.

Figure 2 – Health Risk Screener Response Guidelines (Page 1 of 2)



INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
FSSA
"People helping people help themselves"

Michael R. Pence, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Indiana Office of Medicaid Policy and Planning
IHCP Health Risk Screener Response Guidelines

When reporting member responses for the Adult or Child Health Risk Screener, the following guidelines must be adhered to for accuracy in data collection.

- ALL screener questions are REQUIRED to be asked of all members, dependent on question related rules (i.e. gender specific, age range, follow-up based on response)
- Valid responses are noted on the screener form in a check box format.
  - Yes
  - No
  - Don't know
  - Free form text
  - Topic specific (i.e. PHQ-2, Edinburgh Depression Scale, menu of options)

Member refusal– **MR** must be reported when member does NOT answer the question.

- Telephone: Refusal can be verbal or non-verbal.
- Mailed documents: member skips a question, leaves it blank and/or does not mark an answer.

Not Applicable – **N/A** must be reported when a question does not apply to the member:

- Age specific
- Gender specific
- Prior response my indicate that the next question is not applicable (i.e. If Yes go to #1a, if No go to #2)

*Even though N/A was added to all the questions as a viable response, N/A is only appropriate in the above listed scenarios.
If Health Risk Screener is mailed to members:

- MCE has option to revise format and customize form, as long as ALL questions are included (i.e. change the order of the questions);

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Figure 2 – Health Risk Screener Response Guidelines (Page 2 of 2)

- If MCE chooses to reorganize content of the HRS, it is the responsibility of the MCE to submit form through the document review process;
- MCE is the responsible for submitting member responses, accurately paired to corresponding questions, regardless of the order of the questions on a paper/mailed form.
- MCEs should follow-up with member when responses indicate potential for high risk behaviors or conditions: OMPP does not dictate the follow-up assessment questions.

The HRS was developed to detect actionable health risk indicators for on-going healthcare. Much of the content was pulled together from individual assessment tools to provide the health plans with an opportunity to recognize the need for further assessment. OMPP expects the health plans to act on the results when high risk behaviors and conditions are revealed.
Follow-up may include:

- Conducting additional in-depth assessment of a specific health concern
- Contacting member for more information about a health concern
- Asking additional questions, such as "What challenges have you experienced when you try to …"

Appendix D: Primary Medical Provider Assignments from the Managed Care Entities

Managed care entities (MCEs) assign their members to primary medical providers (PMPs) and must report the assignment information to *Core*MMIS. The following are information supplements about the interface specifications.

File Data

Input fields sent to the fiscal agent by the Healthy Indiana Plan (HIP) MCEs include the following:

- Members' ID – Required, 12 numeric characters
- Member's start date – Required, eight characters (CCYYMMDD)
- Member's start reason – From Assignment Reasons Tab
  - Auto-assigned previous PMP
  - Auto-assigned case ID PMP
  - Auto-assigned PMP in previous group
  - Auto-assigned case ID in previous group
  - Default auto assignment
  - PMP disenrolled
  - Member request
  - PMP initiated
- Member's end date – Required, eight characters (CCYYMMDD)
- Member's stop reason – From Assignment Reasons Tab
- PMP's Medicaid Provider ID – Required, nine numeric characters
- PMP's Medicaid location, individual or group – Required, one alpha character
- Member's health program –H (HIP)
- PMP's Medicaid group Provider ID – If present, nine numeric characters or eight numeric characters followed by one alpha character
- MCE ID – Required, nine numeric characters
- PMP's region code – null for HIP
- Transaction type – A (add), C (change or termination), or D (deleted = terminated before effective date because of an error in eligibility)
- Member's first name – 13 characters
- Member's middle initial – One character
- Member's last name – 15 characters

Output fields sent by the fiscal agent to HIP MCEs include the following:

- Members' ID – Required, 12 numeric characters
- Member's start date – Required, eight characters (CCYYMMDD)

- Member's start reason – From Assignment Reasons Tab
- Member's end date – Required, eight characters (CCYYMMDD)
- Member's stop reason – From Assignment Reasons Tab
- PMP's Medicaid Provider ID – Required, nine numeric characters
- PMP's Medicaid location, individual or group – Required, one alpha character
- Member's health program – H (HIP)
- PMP's Medicaid group Provider ID – If present, nine numeric characters or eight numeric characters followed by one alpha character
- MCE ID – Required, nine numeric characters
- PMP's region code – null for HIP
- Transaction ID – 12 characters
- Transaction type – A (add), C (change or termination), or D (deleted = terminated before effective date because of error in eligibility)
- Error Reasons one through 10 – Three characters each

Process Notes

- MCEs can delete a member's PMP assignment. MCEs must use the one character "D" value for the Transaction type. The assignment must be future dated for the MCE to use this transaction.
- If the MCE submits a member assignment with overlapping start and end dates, the system overwrites the member's new PMP assignment over the old assignment. *Core*MMIS windows reflect the new PMP information, including new start and stop dates, and PMP start and stop reasons.
- MCEs must not use the one character "T" value for the Transaction type. This code is reserved for use by the enrollment broker.
- MCEs can submit future-dated PMP assignments if the member is currently linked to their MCE.
- HIP members in ESP are not part of this PMP assignment process.
- Hoosier Care Connect member process is not affected by these HIP linking assignment changes.
- PMP assignment end-dates are now adjusted to coincide with the Indiana Health Coverage Programs (IHCP) eligibility end-date, if the submitted end-date is after the Medicaid end-date.
- MCEs are not prevented from submitting an end-date on the PMP assignment input file if they're aware the member is terminating in the future.
- MCEs do not receive an error response if *Core*MMIS adjusts the member's PMP assignment end-date, compared to what was submitted on the assignment input file.

Transaction Codes and Their Usage

Table 33 – Transaction Codes and Their Usage

TXN Type	Usage	Date Effective	Date End	Notes
A	Used by the MCEs to replace a placeholder assignment, or to change a PMP assignment	Effective date of the PMP assignment	End date of the PMP assignment	Primary transaction used by the MCEs. Effective date must be current or future date. If < the run date, *Core*MMIS resets the effective date to the run date. MCEs do not need to send a corresponding Term or Change transaction. PMP assignment end-dates are adjusted to coincide with the IHCP eligibility end-date, if the submitted end-date is > the Medicaid end-date.
C	Used by the MCEs when they want to end an assignment but do not have a PMP replacement yet	Effective date of the PMP assignment being ended	End date of the PMP assignment	*Core*MMIS creates the PMP placeholder assignment effective the day after the PMP assignment end-date. PMP assignment end-dates are adjusted to coincide with the IHCP eligibility end-date, if the submitted end-date is > the Medicaid end-date.
D	Used by the MCEs when they want to delete a future-dated PMP assignment	Effective date of the PMP assignment being deleted	End date of the PMP assignment being deleted	An assignment cannot be deleted if it has already taken effect.
T	Not for use by MCEs; reserved for the enrollment broker	N/A	N/A	N/A

Table 34 – PMP Assignment and Eligibility Scenarios

ID	Scenario	Effect on Submissions	Effect on Current Assignments
1	HIP member maintains their eligibility.	No effect. MCEs are able to make changes.	No effect; the assignment remains on file.
2	HIP member loses their eligibility; member is not reopened.	MCEs are not able to submit PMP assignments beyond the HIP eligibility end-date.	The PMP assignment is systematically end-dated in conjunction with the eligibility end-date. An 834 term record is sent to the MCE.
3	HIP member loses their eligibility; member is	The original PMP assignment reopens; therefore, the MCE	The original PMP assignment is end-dated in conjunction with the IHCP

ID	Scenario	Effect on Submissions	Effect on Current Assignments
	reopened without a break in coverage.	does not have to resend the PMP assignment.	eligibility end-date. An 834 term record is sent to the MCE. When eligibility is reopened, the member's PMP assignment also reopens as if it was never closed. An 834 change record generates, indicating a change in eligibility dates.
4	HIP member loses their eligibility; member is reopened after a break in coverage.	MCEs have to submit a PMP assignment after the member is reopened.	The original PMP assignment is end-dated in conjunction with the IHCP eligibility end-date. An 834 term record is sent to the MCE. When eligibility is reopened, the member is assigned retroactively back to the MCE placeholder. HIP members do not have fee-for-service (FFS) periods.

Appendix E: Auto-Assignment Reason Codes

Applicants have the option to preselect their managed care entity (MCE) when applying for the Healthy Indiana Plan (HIP) program. This information is transmitted from the Indiana Eligibility Determination Services System (IEDSS) to *Core*MMIS after the member is determined fully eligible. If there is no MCE preselection, *Core*MMIS auto-assignment logic assigns the member to a HIP plan based on their eligibility.

- MCE Assignment
- Post-MCE Assignment
- Post-PMP Assignment
- PMP Disenrollment

The following table provides the auto-assignment reason codes and descriptions used for the HIP program.

Table 35– Active HIP Auto-Assignment Reason Codes

ID	Description
AA	Auto Assign – Default
AB	Auto Assign – Previous Insurer HIP
AC	Auto Assign – Previous Insurer Hoosier Healthwise
AD	Auto Assign – Spouse HIP
AE	Auto Assign – Spouse HHW
AS	Auto Assigned – Spouse
HL	HIP Lock In Current Calendar Year
MS	Member Selection on Application
3C	Auto Assigned – Previous RCP

Appendix F: MCE Enrollment Form

Figure 4 – MCE Enrollment Form (1 of 3)

| *Core*MMIS MCE/PACE Enrollment Form

MCE/PACE Organization Profile Form Instructions

To enroll as an Indiana Health Coverage Programs (IHCP) managed care entity (MCE) or Program of All-Inclusive Care for the Elderly (PACE) organization, the entity must complete this form and submit it to the DXC Care Programs Manager.

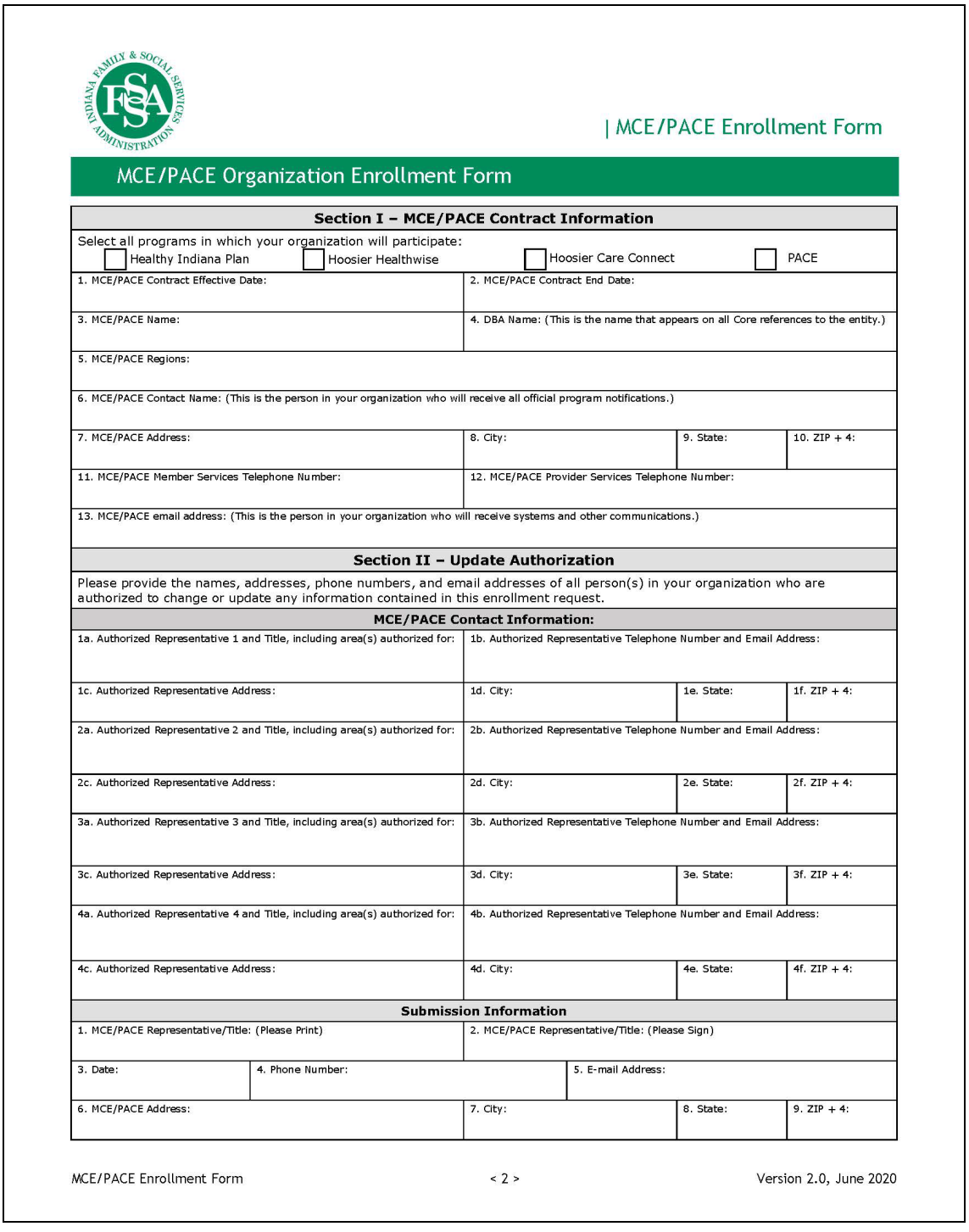
A Trading Partner Agreement and Trading Partner Profile must also be completed in order to set up the Electronic Data Interchange (EDI) for the Health Insurance Portability and Accountability Act (HIPAA) electronic transactions. These forms are available online at the *Trading Partner Registration* page.

IHCP Companion Guides (production version 5010) are available online on the *IHCP Companion Guides* page.

Date DXC Received:	

MCE/PACE Enrollment Form < 1 > Version 2.0, June 2020

Figure 4 – MCE Enrollment Form (2 of 3)



| MCE/PACE Enrollment Form

MCE/PACE Organization Enrollment Form

Section I – MCE/PACE Contract Information

Select all programs in which your organization will participate:
☐ Healthy Indiana Plan ☐ Hoosier Healthwise ☐ Hoosier Care Connect ☐ PACE

1. MCE/PACE Contract Effective Date:	2. MCE/PACE Contract End Date:		
3. MCE/PACE Name:	4. DBA Name: (This is the name that appears on all Core references to the entity.)		
5. MCE/PACE Regions:			
6. MCE/PACE Contact Name: (This is the person in your organization who will receive all official program notifications.)			
7. MCE/PACE Address:	8. City:	9. State:	10. ZIP + 4:
11. MCE/PACE Member Services Telephone Number:	12. MCE/PACE Provider Services Telephone Number:		
13. MCE/PACE email address: (This is the person in your organization who will receive systems and other communications.)			

Section II – Update Authorization

Please provide the names, addresses, phone numbers, and email addresses of all person(s) in your organization who are authorized to change or update any information contained in this enrollment request.

MCE/PACE Contact Information:

1a. Authorized Representative 1 and Title, including area(s) authorized for:	1b. Authorized Representative Telephone Number and Email Address:		
1c. Authorized Representative Address:	1d. City:	1e. State:	1f. ZIP + 4:
2a. Authorized Representative 2 and Title, including area(s) authorized for:	2b. Authorized Representative Telephone Number and Email Address:		
2c. Authorized Representative Address:	2d. City:	2e. State:	2f. ZIP + 4:
3a. Authorized Representative 3 and Title, including area(s) authorized for:	3b. Authorized Representative Telephone Number and Email Address:		
3c. Authorized Representative Address:	3d. City:	3e. State:	3f. ZIP + 4:
4a. Authorized Representative 4 and Title, including area(s) authorized for:	4b. Authorized Representative Telephone Number and Email Address:		
4c. Authorized Representative Address:	4d. City:	4e. State:	4f. ZIP + 4:

Submission Information

1. MCE/PACE Representative/Title: (Please Print)	2. MCE/PACE Representative/Title: (Please Sign)		
3. Date:	4. Phone Number:	5. E-mail Address:	
6. MCE/PACE Address:	7. City:	8. State:	9. ZIP + 4:

MCE/PACE Enrollment Form < 2 > Version 2.0, June 2020

Figure 4 – MCE Enrollment Form (3 of 3)

| Electronic Funds Transfer

Electronic Funds Transfer

General Information for Capitation			
THE FOLLOWING APPLIES TO PER MEMBER PER MONTH CAPITATION FUNDS Complete all fields on this form and attach a voided check or one of your bank deposit slips. Obtain the ABA transit routing number from your bank.			
1. MCE/PACE Organization Name:			
2. MCE/PACE Organization Identification Number:			
3. MCE/PACE Tax ID Type:	4. MCE/PACE Tax ID Number:	5. Tax ID Effective Date:	6. Tax ID End Date:
7. Name on Account:	8. Bank Name:		
9. ABA Transit Routing Number:	10. Bank Account Number:		
11. Bank Address:			
12. City:	13. State:	14. ZIP + 4:	
15. Bank Telephone Number:	16. Type of Account ☐ Savings ☐ Checking		
17. Type of Authorization: ☐ Start ☐ Cancel ☐ Change			
Please include one of the following documents with this form for verification of account owner and account numbers: voided check, deposit slip, or a copy of a bank statement listing the bank account number and the account holder's name.			
On behalf of the MCE/PACE organization named above, I agree to keep, and disclose upon request to authorized agencies, records that fully disclose the extent of payments claimed from and services rendered to members of the Indiana Health Coverage Programs (IHCP). I accept, as payment in full, the amount paid by IHCP for capitation and/or claims submitted with the exception of authorized cost sharing by members. I understand payments are from state and federal funds, any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. This is to ensure that the information submitted to obtain payment is true, accurate, and complete. I authorize the electronic transfer of Indiana Health Coverage Programs payments made to the above identification number. I understand that I am responsible for the validity of the above information. **This section must be completed by an authorized officer.**			
18. MCE/PACE Representative and Title:	19. Telephone Number:		
20. Signature:	21. Date:		
It will take approximately four weeks for this information to be processed by IHCP and validated by your bank. Please send this form to the DXC Care Programs Manager, via email, or postal mail to 950 N. Meridian Street, Suite 1100, Indianapolis, IN 46204.			

MCE/PACE Enrollment Form < 3 > Version 2.0, June 2020

Appendix G: Extracts and Reports

Table 36 depicts extracts and reports that are shared with or submitted to the MCEs on a regular basis. These extracts and reports are generated by the state Fiscal Agent or the FSSA Enterprise Data Warehouse (EDW).

Table 36: Extracts and reports shared with or submitted to the MCEs on a regular basis.

Report/Extract Title	Topic	Frequency	Definition of Report/ Extract	Source	File Location
Provider - HPB Provider File	Provider	Monthly	The Health Professions Bureau file contains IHCP provider medical license information.	Gainwell	File Exchange
Provider Revalidation file	Provider	Monthly	Listing of providers where revalidation date listed is greater than or equal to the run date of job.	Gainwell	File Exchange
Provider Address File	Provider	Daily	File contains the provider address related information. This includes information about multiple locations for a provider.	Gainwell	File Exchange
Provider Base ID Xref File	Provider	Daily	File contains a cross reference list of Base ID and Provider ID (MCD) taken from T_PR_IDENTIFIER.	Gainwell	File Exchange
Provider Service Location Eligibility File	Provider	Daily	File contains provider program eligibility related information (i.e., start/end dates, programs, etc.) by service location.	Gainwell	File Exchange
Provider Group File	Provider	Daily	File contains provider information related to the provider and associated provider group.	Gainwell	File Exchange
Provider Specialty File	Provider	Daily	File contains provider information related to the specialized area of practice for a provider.	Gainwell	File Exchange
Provider Tax ID File	Provider	Daily	File contains provider information related to the tax identification number assigned by the Internal Revenue Service.	Gainwell	File Exchange
Provider UPIN file	Provider	Daily	File contains the provider's universal provider identification number and classification information.	Gainwell	File Exchange
Provider NPI Crosswalk file	Provider	Daily	File contains NPI cross walk information including Provider ID, Group Provider ID, NPI, start/end dates, zip code+4, NPI status code, provider class/type, and associated taxonomy code(s).	Gainwell	File Exchange
Provider NPI STUB file	Provider	Daily	List of NPI Providers with their associated default Provider ID. This is used when a single Provider ID cannot be determined using the NPI, Taxonomy and Zip +4.	Gainwell	File Exchange
Provider PROV STUB file	Provider	Daily	List of active Atypical Providers	Gainwell	File Exchange
Provider QP Eligibility file	Provider	Daily	Presumptive Eligibility (PE) of Qualified Providers (QP) Extract	Gainwell	File Exchange

Report/Extract Title	Topic	Frequency	Definition of Report/ Extract	Source	File Location
Enrollment - 834 Member Enrollment – Daily Change files	Eligibility	Daily	Member adds/changes/terms/voids	Gainwell	File Exchange
Enrollment - 834 Member Enrollment – Bimonthly Audit files	Eligibility	Bimonthly (2nd & 16th)	Members active as of the 1st or 15th of the month.	Gainwell	File Exchange
Enrollment - 834 Member Enrollment – Monthly Term Audit Files	Eligibility	Monthly (5th)	Contains member terms since the last file.	Gainwell	File Exchange
Enrollment - 834 Member Enrollment – Monthly Term Change Files	Eligibility	Monthly (20th)	Contains retroactive changes to termed eligibility segments.	Gainwell	File Exchange
Enrollment - Medicare Interface	Eligibility	Monthly	This file is sent from Gainwell to the MCEs and provides member Medicare data.	Gainwell	File Exchange
Enrollment - Third Party Liability (TPL) Interface	Eligibility	Monthly (26th of the month)	TPL File to MCEs	Gainwell	File Exchange
Enrollment - MCE Supplemental file	Eligibility	Monday - Friday	Supplemental file from MCE to Gainwell with Cost Share and Pregnancy info	MCE to Gainwell	File Exchange
Enrollment - MCE Supplemental Response file	Eligibility	Daily	Response file for the member supplemental file	Gainwell	File Exchange
Finance - 820 Monthly Capitation	Capitation	Monthly (following third Wednesday)	Monthly Capitation and Reconciliation transactions	Gainwell	File Exchange
Capitation Forecast Report (MGD-0305-M & E)	Capitation	1st Wednesday of month	MGD-0305-M & E. A forecast for following month.	Gainwell	File Exchange
Capitation Adjustment Forecast Report (MGD-0304-M&E)	Capitation	Monthly	MGD-0304-M&E. This is posted to MCEs File Exchange folder by the Business Unit and includes adjustments to be paid or recouped in the following month	Gainwell	File Exchange
Member PMP assignment history file	PMP Assignment	Daily	This is the Member PMP Assignment History file that Gainwell will send to the MCEs.	Gainwell	File Exchange
Member PMP Assignment file	PMP Assignment	Monday - Friday	PMP assignment posting file from MCE to Gainwell	MCE to Gainwell	File Exchange
Member PMP Assignment Response File	PMP Assignment	Monday - Friday	Response file for the PMP assignment file that MCE sends to Gainwell	Gainwell	File Exchange
Notification of Pregnancy (NOP) Extracts	NOP	Monday - Friday	This XML file is the daily Outbound NOP Extract sent to the MCEs from Gainwell.	Gainwell	File Exchange
Notification of Pregnancy (NOP) Risk File	NOP	Monday - Friday	This XML file is an NOP Extract Response file from the MCEs to Gainwell with risk levels populated.	MCE to Gainwell	File Exchange
Encounters - 837I Institutional Claims Encounters	Encounters	Daily	Institutional Claim Encounters	MCE to Gainwell	File Exchange
Encounters - 837P Professional Claims Encounters	Encounters	Daily	Professional Claims Encounters	MCE to Gainwell	File Exchange
Encounters - 837D Dental Claims Encounters	Encounters	Daily	Dental Claims Encounters	MCE to Gainwell	File Exchange

Report/Extract Title	Topic	Frequency	Definition of Report/ Extract	Source	File Location
Encounters - 999 Functional Acknowledgement Response for 837s	Encounters	Daily	837 Functional acknowledgment response	MCE to Gainwell	File Exchange
Encounters - TA1 Acknowledgement for 837s	Encounters	Daily	837 TA1 response	MCE to Gainwell	File Exchange

Appendix H: OMPP Rate Equalization Physician Reimbursement Adjustment Policies

Table 37: OMPP Rate Equalization Physician Reimbursement Adjustment Policies

Office of Medicaid Policy and Planning
Rate Equalization
Physician Reimbursement Adjustment Policies
January 1, 2024 Policies Highlighted in Yellow

	Reimbursement Adjustment	Indiana Policy	Medicare Policy	Identifier
1	**Practitioner Adjustments**			
1.1	APRN employed by physicians or are working in a physician-directed group	100%	85%	Provider type 09, provider specialties 090, 091, 092, 093, 095
1.2	APRN enrolled as a billing provider or as a rendering provider within an APRN group enrollment	75%		
1.3	APRNs providing behavioral health, regardless of independent or physician-employed status	75%		
1.4	CRNA	60%	CRNA medically directed – 50%	Modifier QX
			CRNA not medically directed – 100%	Modifier QZ
1.5	Physician Assistant	75%	85%	Provider type 10, provider specialty 100
1.6	Clinical Psychologist	75%	100%	Modifier HE; excludes MRO services (reimbursed at 100%)
1.7	Licensed Clinical Social Worker	75%	75%	Modifier HE; excludes MRO services (reimbursed at 100%)
1.8	Other non-physician behavioral health: Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, Licensed Clinical Addiction Counselor	75%	None found	Modifier HE; excludes MRO services (reimbursed at 100%)
1.9	Physical therapist assistant	75%	None found	Modifier HM
1.10	Speech-language pathologist aide	75%	None found	Modifier HM
1.11	Co-surgeons	62.5%	62.5%	Modifier 62

1.12	Physician – assistant at surgery	20%	16%	Modifiers 80, 81, 82
1.13	APRN – assistant at surgery	20%	13.6% (85% of 16%)	Modifier AS
1.14	PA – assistant at surgery	20%	13.6% (85% of 16%)	Modifier AS
2	**Procedure-Based Adjustments**			
2.1	Multiple Surgery	• 100% of the global fee for the most expensive procedure • 50% of the global fee for the second most expensive procedure • 25% of the global fee for the remaining procedures	• 100% of the global fee for the most expensive procedure • 50% of the global fee for the remaining procedures	• Modifier 51 • Multiple Procedure ("MULT PROC") indicators from the Medicare physician fee schedule RVU file
2.2	Multiple Endoscopy Procedures (if all procedures are endoscopy procedures; otherwise standard multiple surgery rules apply)	N/A	• 100% of the most expensive procedure • Difference between next highest and 3rd highest procedure	Indicator of "3" from the Multiple Procedure ("MULT PROC") field of the Medicare physician fee schedule RVU file
2.3	Bilateral Surgery	150%	150%	• No modifier if inherently bilateral (procedure is identified by terminology as bilateral) • Modifier 50 if not inherently bilateral
3	**Site of Service Adjustment**			
3.1	Site of Service Payment Adjustment	• 80% of the Medicaid non-facility practice expense (PE) RVUs • Medicaid place of service codes	• Medicare facility PE RVUs • Medicare place of service codes	Medicare physician fee schedule PE RVUs and Medicare place of service codes

Medicaid place of service codes

- 19 Off campus-outpatient hospital
- 22 On campus-outpatient hospital
- 23 Emergency room
- 62 Comprehensive outpatient rehabilitation facility

Medicare place of service codes

- 02 Telehealth
- 19 Outpatient Hospital-Off campus
- 21 Inpatient Hospital
- 22 Outpatient Hospital-On campus
- 23 Emergency Room-Hospital
- 24 Ambulatory surgical center (ASC)
- 26 Military Treatment Facility

- 31 Skilled Nursing Facility (SNF)
- 34 Hospice
- 41 Ambulance – Land
- 42 Ambulance – Air or Water
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility -- Partial Hospitalization
- 53 Community Mental Health Center
- 56 Psychiatric Residential Treatment Center
- 61 Comprehensive Inpatient Rehabilitation Facility