INDIANA HEALTH COVERAGE PROGRAMS

MANAGED CARE ENTITY POLICIES AND PROCEDURES MANUAL

Hoosier Healthwise MCE Policies and Procedures Manual

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Table of Contents

Section 1: Background **1**
1.1 Hoosier Healthwise 1
1.2 Managed Care Entity Orientation 2
Section 2: Managed Care Entity – Contractor Requirements **5**
2.1 State Licensure 5
2.2 National Committee for Quality Assurance (NCQA) Accreditation 5
2.3 Administrative and Organizational Structure 6
2.3.1 Staffing 6
2.3.2 Key Staff 6
2.3.3 Staff Positions 11
2.3.4 Staff Training and Qualifications 13
2.3.5 Debarred Individuals 14
2.4 State Meeting Requirements 14
2.5 Financial Requirements 15
2.5.1 Solvency 15
2.5.2 Insurance 15
2.5.3 Reinsurance 15
2.5.4 Financial Accounting Requirements 16
2.5.5 Reporting Transactions with Parties of Interest 17
2.5.6 Types of Disclosure Transactions 18
2.5.7 Medical Loss Ratio 18
2.6 Subcontracts 19
2.7 Confidentiality of Members' Medical Records and Other Information 21
2.8 Internet Quorum Inquiries 22
2.9 Material Changes 22
2.9.1 Data Requests 22
Section 3: Covered Benefits and Services **23**
3.1 Hoosier Healthwise Covered Services 23
3.2 Self-Referral Services 24
3.3 Early and Periodic Screening, Diagnostic, and Treatment Services 26
3.3.1 Hoosier Healthwise EPSDT Services 27
3.3.2 Prenatal and Pregnancy-Related Care 27
3.3.3 Future Standards 28
3.4 Pharmacy Benefits: Hoosier Healthwise 29
3.4.1 Drug Rebates 29
3.4.2 Preferred Drug List and Formulary Requirements 29
3.4.3 Individual Carved Out Drugs 30
3.4.4 DUR Board Reporting Requirements 30
3.4.5 Dispensing and Monitoring Requirements 31
3.4.6 E-Prescribing 32
3.4.7 340B 32
3.5 Emergency Care 33
3.5.1 Post Stabilization Care 34
3.6 Behavioral Health 34
3.6.1 Behavioral Healthcare Services 35
3.6.2 Behavioral Health Provider Network 36
3.6.3 Case Management for Members Receiving Behavioral Health Services 37
3.6.4 Behavioral Healthcare Coordination 38
3.6.5 Behavioral Health Continuity of Care 39
3.6.6 Partial Hospitalization Services for Behavioral Health 39

3.6.7 Institutions for Mental Disease 40
3.7 Disease Management 40
3.7.1 Population-Based Interventions 42
3.7.2 Care Management 42
3.7.3 Case Management 42
3.8 24-Hour Nurse Call Line 43
3.9 Carve-outs and Related Services 44
3.9.1 Services Carved Out of Risk-Based Managed Care Capitation 44
3.10 IHCP-Covered Services Excluded From Hoosier Healthwise 44
3.11 Short-Term Placements in Long-Term Care Facilities 46
3.11.1 Hospice 46
3.11.2 1915(c) Home- and Community-Based Waiver Services 46
3.11.3 Psychiatric Treatment in a State Hospital 46
3.11.4 Psychiatric Residential Treatment Facility (PRTF) Services 46
3.12 Continuity of Care 47
3.13 Out-of-Network Services 48
3.13.1 Out-of-Network Provider Reimbursement 49
3.13.2 Extended Inpatient Hospital Stays for Children Investigated by the DCS 49
3.14 Hoosier Healthwise Members Pending Level of Care Determination 50
3.15 Women, Infants and Children Infant Formula for Hoosier Healthwise Members 50
3.16 Provision of Enhanced Services in Risk-Based Managed Care 51
3.17 Member Financial Responsibility 51
3.17.1 Copayments and Cost-Sharing in Hoosier Healthwise Package C 51
3.17.2 Charging Members for Services Rendered 52

Section 4: Member Services 53

4.1 Marketing and Outreach 53
4.1.1 General Information Review, Approval and Requirements 54
4.2 Member Enrollment 55
4.2.1 New Member Materials 56
4.2.2 Health Needs Screen and Comprehensive Health Assessment 56
4.2.3 Health Needs Screen Extract 57
4.2.4 Members With Special Healthcare Needs 57
4.2.5 Member Disenrollment 59
4.3 Member – MCE Communications 60
4.3.1 Managed Care Entity Member Services Helpline 60
4.3.2 Electronic Communications 62
4.4 Member Information, Outreach and Education 63
4.4.1 Member Handbook 64
4.4.2 Member Website 67
4.4.3 Preventive Care Information 68
4.4.4 Member Communications - Returned Mail 68
4.4.5 Cost and Quality Information 69
4.5 Redetermination Assistance 69
4.6 Hoosier Healthwise Eligibility Redetermination 70
4.6.1 Member Appeals Ineligibility Decision at Redetermination 71
4.6.2 Changing Managed Care Entities Without Cause at the End of a Coverage Term72
4.7 Member-Provider Communication 72
4.8 Member Grievances and Appeals 73
4.8.1 Member Notice of Grievance, Appeal and Fair Hearing Procedures 77
4.9 Oral Interpretation Services 77
4.10 Cultural Competency 78
4.11 MCE Application Assistance and Distribution to Nonmembers 78
4.12 SNAP Alignment Language 79
4.13 Risk-Based Managed Care and Aid Categories 80
4.13.1 Retroactive Eligibility 81

4.13.2 Identification Cards 82
4.13.3 Member Enrollment 83
4.13.4 Member Enrollment Rosters 83
4.13.5 Hoosier Healthwise Enrollment 84
4.13.6 Elements Unique to Hoosier Healthwise Enrollment Rosters 85
4.13.7 Children's Health Insurance Program Enrollment 86
4.14 Eligibility Verification 86
4.14.1 Eligibility Verification System 86
4.15 Auto-Assignment 89
4.16 Preferred Medical Provider Selection 90
4.17 PMP Assignment History File From Fiscal Agent to the MCE 90
4.18 Primary Medical Provider Assignments From the MCEs to Fiscal Agent 92
4.19 Changing Managed Care Entities 92
4.19.1 Open Enrollment Scenarios 94
4.20 Assumptions 94
4.20.1 General Enrollment Framework 94
4.20.2 Member Changes Managed Care Entities During 60-Day Free-change Period 95
4.20.3 Member Changes Managed Care Entities for Just Cause 95
4.20.4 Exceptions to 12-Month Managed Care Entity Enrollment 97
4.20.5 Newborn Scenario 97
4.20.6 Family Member Free-Change Periods 97
4.21 Presumptive Eligibility (PE) 97
4.22 Notification of Pregnancy 98
4.22.1 Portal Recognized Providers for Notification of Pregnancy 98
4.22.2 Notification of Pregnancy Process 98
4.22.3 Newborn Prebirth Selection 104
4.22.4 Provider-Initiated Requests for Member Reassignment 104

Section 5: Provider Network Requirements 107

5.1 Network Development 107
5.2 Network Composition Requirements 108
5.2.1 Acute Care Hospital Facilities 109
5.2.2 Primary Medical Provider (PMP) Requirements 109
5.2.3 Specialist and Ancillary Provider Network Requirements 111
5.2.4 Pharmacies 112
5.2.5 Non-Psychiatrist, Non-SUD Behavioral Health Providers 113
5.2.6 Inpatient Psychiatric Facilities 113
5.2.7 SUD Providers 114
5.2.8 Dental Providers 114
5.2.9 Physician Extenders 114
5.2.10 Federally Qualified Health Centers and Rural Health Clinics 115
5.2.11 School-Based Clinics 116
5.2.12 Indian Healthcare Providers 117
5.2.13 County Health Departments 119
5.2.14 Urgent Care Clinics 119
5.2.14 Dialysis Treatment Center 119
5.2.15 OB/GYNs 119
5.2.16 Non-emergency Medical Transportation Providers 119
5.3 Provider Agreements 119
5.4 Provider Credentialing and Recredentialing Policies and Procedures 121
5.4.1 Credentialing 121
5.4.2 Mechanisms for Credentialing and Recredentialing 122
5.4.3 Credentialing – Initial Visit 123
5.4.4 Recredentialing 123
5.4.5 Recredentialing Practice Site Visit 124
5.4.6 Altering Conditions of Provider Participation 124

5.4.7 Credentialing Provider Healthcare Delivery Organizations 124
5.4.8 Clinical Laboratory Improvement Amendments 125
5.5 Maintenance of Medical Records 125
5.6 Provider Education and Outreach Activities 126
5.6.1 Provider Policies and Procedures Manual 127
5.6.2 Provider Website 127
5.6.3 Provider Services Helpline 128
5.6.4 IHCP Workshops and Seminars 129
5.6.5 Provider Welcome Letter 129
5.7 Provider Service Locations 130
5.7.1 Out-of-State Providers 130
5.7.2 Residency Programs 132
5.7.3 Presumptive Eligibility Qualified Provider Enrollment 132
5.7.4 Pre-Enrollment Provider Education 132
5.7.5 Post-Enrollment Provider Education 133
5.8 Hospital Assessment Fee 134
5.9 Managed Care Entity Enrollment in *Core*MMIS 134
5.10 Managed Care Entity Provider Network Requirements 135
5.11 Provider Network Participation Requests 135
5.11.1 Network Participation Process 135
5.11.2 Provider Network Participation Request Forms 137
5.11.3 Provider Effective Dates 137
5.11.4 Provider Network Participation Documentation 139
5.11.5 Annual Review of Provider Network Participation Process 139
5.12 Provider Enrollment 140
5.12.1 Indiana Health Coverage Programs Provider Enrollment Processing 141
5.12.2 IHCP Electronic Provider Files 142
5.12.3 Managed Care Entity Preferred Medical Provider Enrollments and Updates 142
5.12.4 Linking Preferred Medical Providers to Managed Care Entity Networks 143
5.13 Changes to Preferred Medical Provider Scope of Practice 143
5.14 Provider Disenrollment 144
5.14.1 Steps for Disenrolling a Preferred Medical Provider 144
5.15 IHCP Disenrollment and Preferred Medical Provider Disenrollment 145
5.16 Managed Care Entity Communications with Providers 145
5.17 Provider Dispute Procedures 145
5.18 Practice Standards 146
5.18.1 Universally Accepted Practice Standards 146
5.19 Billing and Reimbursement Policies and Procedures 147
5.19.1 Interest Payments to Non-Contracted Providers 147
5.19.2 Billing and Balance Billing IHCP Enrollees 148
5.19.3 Future Recovery Effort Due to Retroactive Medicare Eligibility 149
5.19.4 Disclosure of Physician Incentive Plan 149
5.19.5 School-Based Healthcare Services 150
5.19.6 Direct Payment for Eligible Out-of-State Children's Hospitals 151

Section 6: Quality Management and Utilization Management 153

6.1 Quality Management and Improvement Program 154
6.1.1 Quality Management and Improvement Program Documents 155
6.1.2 External Quality Review 156
6.2 Utilization Management Program 156
6.2.1 Mandatory Medical Criteria Hierarchy – Effective 04/01/23: 156
6.2.2 The Right Choices Program 160
6.2.3 Authorization of Service and Notice of Action 161
6.2.4 Requirements for Tracking Prior Authorization Requests 163
6.2.5 Objection on Moral or Religious Grounds 163
6.2.6 Utilization Management Committee 164

Section 7: Program Integrity 165
7.1 Program Integrity Plan 165
7.1.1 Additional Program Integrity Requirements 166
7.2 Program Integrity Operations 168
7.3 Program Integrity Reporting 168
7.3.1 Reporting Waste, Fraud and Abuse 169
7.3.2 Investigation of Waste, Fraud, and Abuse 169
7.3.3 Credible Allegation of Fraud 169
7.3.4 Audit Report 169
7.3.5 HIPAA or Other Security Breach 170
7.4 Medical Management Standard Compliance 170
7.5 Auditing Program Integrity Operations 171

Section 8: Information Systems 173
8.1 Program Integrity Overpayment Recovery 174
8.2 Disaster Recovery Plan 175
8.3 Encounter Data Submission 176
8.3.1 Weekly Batch Submission 177
8.3.2 Precycle Edits 177
8.3.3 Encounter Claims Quality 178
8.4 Encounter Data Edits and Audits 179
8.4.1 Encounter Data Output Documents 180
8.4.2 Encounter Data Corrections and Resubmissions 180
8.4.3 Encounter Data Adjustments 181
8.5 Member Enrollment and Capitation Data Exchange 181
8.6 Claim Processing 182
8.6.1 Claim Processing Capability 183
8.6.2 Compliance With State and Federal Claim Processing Regulations 183
8.6.3 Claim Payment Timelines 183
8.5.4 Medicaid National Correct Coding Initiative (NCCI) 184
8.6.4 Capitation Adjustments – Systematic 184
8.6.5 Capitation Adjustments – Manual 185
8.7 Rate Information 185
8.7.1 IHCP Fee Schedules 185
8.7.2 Supplemental IHCP Rate Information 186
8.7.3 Claim Elements Unique to Hoosier Healthwise Encounter Data 186
8.8 Third-Party Liability 189
8.8.1 Third-Party Liability Coordination of Benefits 189
8.8.2 Hoosier Healthwise Package A 190
8.8.3 Hoosier Healthwise Package C 190
8.8.4 Third-Party Liability Data Sources 190
8.8.5 MCE TPL Responsibilities – Cost Avoidance and Coordination of Benefits 191
8.8.6 Cost Avoidance Exceptions 191
8.8.7 Third-Party Liability Collection and Reporting 191
8.9 Health Information Technology and Data Sharing 192

Section 9 Performance Reporting and Incentives 195
9.1 Incentive Programs 197
9.1.1 Provider Incentive Programs 197
9.1.2 Member Incentive Programs 197
9.1.3 Notification of Pregnancy Incentives 199

Appendix A: Hoosier Healthwise Capitation Payment Transaction Codes 201

Appendix B: Subcontract Approval Checklist 203

Appendix C: Interface Schedule 204

Appendix D: Preferred Medical Provider Assignments From the MCEs 207

File Data....207
Process Notes....208
Transaction Codes and Their Use....208
Appendix E: Auto-Assignment Reason Codes....211
Appendix F: MCE Enrollment Form....213
Appendix G: Extracts and Reports....217

Section 1: Background

The *Hoosier Healthwise MCE Policies and Procedures Manual* is provided to each managed care entity (MCE) contracting with the state to administer services to Hoosier Healthwise members enrolled in the plan. This manual provides an overview of each MCE's role in the Hoosier Healthwise 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 Hoosier Healthwise program objectives and components, and MCE enrollment.
- *Managed Care Entity – MCE Requirements* includes information about eligibility requirements for an MCE, the MCE's expected role in the Hoosier Healthwise program and staffing requirements.
- *Covered Benefits and Services* describes the services that are covered and excluded from the various programs under the managed care umbrella, which includes Hoosier Healthwise. 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 managed care entity's (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 Hoosier Healthwise.
- *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 Hoosier Healthwise members.
- *Quality Management and Utilization Management* is a critical aspect of managed care and expectations, incentive programs, compliance, monitoring, and reporting for Hoosier Healthwise.
- *Program Integrity* defines *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.
- *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.
- *Performance Reporting and Incentives* describes submission of performance data to the state.

In addition to these sections, Appendixes A through J provide information about extracts, forms, and so forth.

1.1 Hoosier Healthwise

Since its inception in 1994, Hoosier Healthwise has expanded from a Medicaid managed care program to a risk-based managed care program serving children and pregnant women. Indiana offers Hoosier Healthwise members comprehensive benefits depending on the aid category in the following two benefit packages:

- Package A – Full coverage for children and pregnant woman.
- Package C – Preventive, primary, and acute care services for some children under 19 years old.

See Member Enrollment for details of each benefit package and the related aid categories.

This manual documents policies and procedures applied to the Hoosier Healthwise component of the IHCP specific to MCEs and their roles in the program. General IHCP policies and information provided in the *IHCP Provider Reference Modules* or elsewhere are referenced and not duplicated in this manual.

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 Hoosier Healthwise 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, is constantly changing to meet the demands of its patients, providers, and payers. Hoosier Healthwise is subject to many of these changes. Hoosier Healthwise 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 Hoosier Healthwise 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 Hoosier Healthwise contractors provide the MCE with a broad range of materials.

The fiscal agent, currently Gainwell, provides the following:

- Claim resolution edits and audits documents are made available, via File Exchange posting to the MCEs twice a year, in January and July.
- IHCP explanation of benefits (EOB) codes are available on the Explanation of Benefits page at in.gov/medicaid/providers.
- IHCP Provider Reference Modules are available on the *IHCP Provider Reference Modules* 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 pages are available from the *News, Bulletins and Banner Pages* page at in.gov/medicaid/providers.
- Electronic file layouts and requirements for data exchanges, including provider extract files and third-party liability files, which are available from the *MCE Secure Landing* page at in.gov/medicaid/providers. 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, 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 also available on the IHCP Companion Guides page at IN.gov/Medicaid. 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 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.
- Procedures for PMP enrollment and disenrollment.
- Member MCE auto-assignment process for Hoosier Healthwise, and information regarding the Hoosier Healthwise open enrollment process.
- 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:
- Hoosier Healthwise 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 the state 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 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 MCE 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

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 MCE 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 a 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 with the FSSA upon request, including during unannounced FSSA site visits.

Except in the circumstance of the unforeseeable loss of a key staff member's service, 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.

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 MCE shall submit to FSSA an updated organizational chart including e-mail addresses and phone numbers for key staff.

2.3.2 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 Hoosier Healthwise. 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 MCE's Indiana Medicaid product lines. This individual is the primary liaison with the state (or its designees) to facilitate communications between the FSSA, the state's contractors, and the MCE's executive leadership and staff. The compliance officer must maintain current knowledge of federal and state legislation, legislative initiatives, and regulations that may affect the Hoosier Healthwise 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 ensuring all MCE functions are compliant with the terms of the contract. The Compliance Officer must meet with the state's 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 Information Technology (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, POWER Account administration, enrollment and other data transmission interface and management issues. The CIO or IT Director, in close coordination with other key staff, is responsible for ensuring all program data transactions are in compliance with the terms of the Contract. The CIO or IT Director is responsible for attendance at all Technical Meetings called by the state. If the CIO or IT Director is unable to attend a Technical Meeting, the CIO or IT Director shall designate a representative to take their place. This representative shall report back to the CIO or IT Director on the Technical Meeting's agenda and action items. This individual oversees the MCE's Hoosier Healthwise information systems and serves as a liaison between the MCE and the state fiscal agent or other state contractors regarding the following:
  - Encounter claim submissions
  - Capitation payment
  - Member eligibility
  - Enrollment and other data transmission interface and management issues
- 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 shall 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 the MCE's Indiana Medicaid product lines and 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 email communications, member education, the member website, member outreach programs, development, and approval and distribution of member materials. The Member Services Manager is responsible for the member grievances and appeals process, and works closely with other managers (especially, the Quality Management 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 limitations, health screenings, emergency services, PMP assignment and changes, specialty provider referrals, self-referral services, preventive and enhanced services, well-child services (Hoosier Healthwise only) 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 MCE's Indiana Medicaid product lines. The Provider Services Manager, at a minimum, must be responsible for the provider services helpline performance, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider 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 Unit. 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 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 health care 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 health care services that improve the health status and health outcomes of Hoosier Healthwise 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 5 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.

- 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 Hoosier Healthwise data conform to Family and Social Services Administration (FSSA) and the 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.
- 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 responsible for ensuring 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 Hoosier Healthwise 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.
- 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 with the state. This individual shall work in collaboration with the IS coordinator to ensure the timely and accurate submission of encounter data.
- Care Management Manager - The MCE must employ a full-time Care Management Manager dedicated to the Hoosier Healthwise 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 MCE'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.

- 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 MCE or subcontractor is compliant with standards of dental care and consistent with this Contract. The Dental Manager establishes and coordinates with implementation of the MCE's oral health strategy to ensure comprehensive, whole person health.
- Member Advocate/Non-Discrimination Coordinator – The MCE must employ a Member Advocate/Non-Discrimination Coordinator dedicated full-time to the Hoosier Healthwise 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 MCE'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.
- Equity Officer – The MCE must employ a full-time Health Equity Officer dedicated to Indiana Medicaid. The Equity Officer will provide leadership and management to define, implement, and evaluate strategies to achieve equitable access and reduce disparities in clinical care and quality outcomes. This strategy must include tracking, assessing, and improving disparities in care, and supporting the diverse cultural, language, economic, education and health status needs of those served by the MCE.

2.3.3 Staff Positions

In addition to required staff 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, 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 joint marketing and outreach efforts for the MCE's Indiana Medicaid product lines.
- Special investigation unit staff – Supports the SIU manager and help 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 a 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.
- Compliance staff – The MCE must employ compliance staff to support the compliance officer and help ensure that all MCE functions are compliant with state and federal laws and regulations, the state's policies and procedures, and the terms of the contract.
- Provider representatives – The MCE must employ provider representatives to develop the MCE's network, and coordinate communications between the MCE and contracted and noncontracted providers, paying particular attention to educating and encouraging providers to participate in the Hoosier Healthwise and other Indiana Medicaid product lines to ensure continuity of care for members transitioning between programs.
- Claim processors – The MCE must employ claim processors to process electronic and paper claims in a timely and accurate manner, process claim correction letters, process claim resubmissions, and address overall disposition of all claims for the MCE, per state and federal guidelines. The MCE must maintain sufficient staff to ensure the submission of timely, complete, and accurate encounter claims data.
- Member and provider education/outreach staff – The MCE must employ 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 policies and procedures; and to identify and address barriers to an effective healthcare delivery system for the MCE's members and providers.
- Website staff – The MCE must employ website staff to maintain and update the MCE's member and provider websites and member portal.
- 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 and member and provider communication through all benefit plan and MCE transfers.

2.3.4 Staff Training and Qualifications

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 Hoosier Healthwise program. Staff training must include, but is not limited to:

- An overview of the HHW program & associated policies and procedures, including updates whenever changes occur;
- Contract requirements and state and federal requirements specific to job functions;
- 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 HHW 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; and
- 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.

The Utilization management staff must receive ongoing training regarding interpretation and application of the MCE's utilization management guidelines. The ongoing training must be conducted, at a minimum, on a quarterly basis and as changes to the MCE's utilization management guidelines and policies and procedures occur.

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 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, subcontractor, 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 the 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 State Meeting Requirements

The state conducts meetings and collaborative workgroups for the Hoosier Healthwise 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 Hoosier Healthwise program.

2.5 Financial Requirements

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 Hoosier Healthwise 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 of reinsurance policies to the state for review and approval at least 120 calendar days before becoming effective. The MCE must submit them 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 coverage 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 (for example, 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 separate accounting records for the Hoosier Healthwise line of business that 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 Hoosier Healthwise 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 agents) 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).*

Definition of *A Party of Interest* – as defined in *§1318(b) of the Public Health Service Act*, a party of interest is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than 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 a HMO; and
- Any spouse, child, or parent of an individual described in the above 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 Hoosier Healthwise 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 85% for the Hoosier Healthwise 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 85%.

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 85%.

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. No subcontract may extend past the term of the contract the MCE has with the state. A reference to this provision and its requirements 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, attorney's 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 *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 Hoosier Healthwise programs.
- 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 Exhibit 2 of the contract, for noncompliance with reporting requirements and performance standards.
- If the MCE uses subcontractors to provide direct services to members, such as care coordination and 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 claim 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 IQ inquiries 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 will subject the MCE to the liquidated damages set forth in Exhibit two 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.

2.9.1 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 FSSA Data and Analytics. The MCEs are not allowed to make data requests to any other state contracted entities, such as the state fiscal agent.

The MCE representative shall contact their OMPP contract manager to request data. The OMPP contract manager will submit the request to FSSA Data and Analytics for review and consideration for approval.

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 OMPP contract manager will alert the MCE. If the state denies the data request, the OMPP 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 data is sent to the OMPP contract manager for review. The OMPP contract manager reviews the data and forwards it to the MCE representative to complete the process.

Section 3: Covered Benefits and Services

This section provides information about the services that are covered and excluded from the various programs covered by the managed care Hoosier Healthwise Plan. 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, and this section also includes information about members who must transfer to another program because of pregnancy, long-term care, and so forth.

3.1 Hoosier Healthwise Covered Services

The services covered by MCEs for which capitation payments are received must be provided to the member in an amount, duration, and scope that is no less than the IHCP-covered services detailed in state regulation *405 IAC 5,* in accordance with federal regulation *42 CFR 438.210*. Services excluded from the MCE's scope of responsibility but covered by the Indiana Health Coverage Programs (IHCP) are referred to as carve outs and are addressed later in this section.

Detailed explanations of Medicaid-covered services and limitations are cited in *405 IAC 5;* Children's Health Insurance Program *(CHIP) (Package C) in 405 IAC 13.* The following are broad categories of services provided by the MCE in arrangement with the state:

- Physician services
- Primary care services
- Preventive health services (including vaccinations added to the periodicity schedule but not yet available through the Vaccines for Children program)
- Therapeutic and rehabilitative services
- Specialty care services
- Hospital services
- Inpatient care
- Outpatient services
- Therapy services
- Diagnostic studies
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Initial and periodic screenings
- Diagnosis and treatment
- Targeted Case Management (members with high blood lead levels)
- Home health services
- Physical, occupational, and respiratory therapy
- Speech pathology
- Renal dialysis
- Medical supplies and equipment
- Medical supplies and durable medical equipment
- Braces and orthopedic shoes
- Prosthetic devices
- Hearing aids

- Transportation services
- Emergency transportation
- Nonemergency transportation (subject to limitations under Package C)
- Transportation
- Diabetes self-management services
- Pregnancy care coordination
- Prenatal care programs targeted to provide better outcomes in high-risk pregnancies
- Newborn healthcare and parenting education
- Smoking cessation and tobacco dependence treatment
- Behavioral health services, such as mental health, substance abuse, and chemical dependency services
- Applied Behavioral Analysis (ABA) Therapy
- Chiropractor (subject to limitations under Package C)
- Dental Services
- Prescription Drugs
- Urgent Care Services
- Vision
- Family Planning Services
- Food Supplements, Nutritional Supplements, and Infant Formulas
- Laboratory and Radiology Services
- Podiatry (subject to limitations under Package C)

Special provisions for specific types of service, coverage, and payment policies apply to some services and providers. These provisions, discussed later in this section, include the following:

- Emergency care services
- Out-of-network services
- Self-referral services
- Behavioral health services
- EPSDT services
- Federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- Extended hospital stays for children involved in investigations by protective services
- Hoosier Healthwise carved-out and related services
- Short-term placements in long-term care facilities
- Continuity of care
- Twenty-four hour nurse call line
- Women, Infants, and Children (WIC) program infant formula
- Disease management

3.2 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 (non-psychiatric) and routine dental services (if covered by member plan), the MCE cannot require members to use MCE-network providers.

When Hoosier Healthwise members choose to receive self-referral services from self-referral providers that are not contracted with the MCE, the MCE is responsible for payment to these providers up to the applicable benefit limits and at IHCP FFS rates.

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:

- Emergency services [any provider; require IHCP enrollment to facilitate payment]
- Urgent care services [any IHCP-enrolled provider]
- Family planning [any IHCP-enrolled provider]
- Immunizations [any IHCP-enrolled provider]
- Podiatry [any IHCP-enrolled provider]
- Psychiatric services [any IHCP-enrolled provider]
- Eye care (except surgery) [any IHCP-enrolled provider]
- Diabetes self-management training [any IHCP-enrolled provider subject to MCE PA requirements]
- Chiropractic services [any IHCP-enrolled provider subject to MCE PA requirements; Package C subject to benefit plan limits]
- Behavioral health (nonpsychiatric) [any MCE network provider]
- Dental (routine) [any MCE network provider]

The Indiana Administrative Code *405 IAC 5* and *405 IAC 13* provide 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*. Chiropractic services provided as a benefit under Package C are subject to limitations as defined in *405 IAC 13-11*. Non-MCE-network providers are subject to MCE PA requirements.
- 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*.
- 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*.
- 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*.
- 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 MCE 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 MCE’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.

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 module provides a complete and current list of family planning services. Under the MCE's Hoosier Healthwise 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, seven 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 & addiction clinics
  - Community mental health centers
  - Licensed clinical addiction counselors
  - Certified psychologists
  - Health service provider in psychology (HSPP)/Certified clinical social workers
  - 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)

3.3 Early and Periodic Screening, Diagnostic, 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 Hoosier Healthwise children. 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 more costly treatment or hospitalization resulting from delayed treatment. See the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch module for details regarding components and recommended frequency of HealthWatch screenings.

3.3.1 Hoosier Healthwise EPSDT Services

The MCE must provide all covered EPSDT services for Hoosier Healthwise members. In covering well-child visits, the MCE must follow the latest guidance from the American Academy of Pediatrics (AAP).

The state encourages MCEs to work with prenatal clinics and other providers to educate pregnant women about the importance of EPSDT screenings and encourage mothers to schedule preventive visits for their infants.

Lead-level screening is an important component of HealthWatch. Based on the state's obligation to monitor the MCE's performance in this area, in accordance with *IC-12-15-12-20*, the state requires MCEs to screen children for lead poisoning. Lead poisoning may cause anemia, permanent brain damage, learning disorders, loss of balance, kidney damage, blindness, hearing loss, seizures, coma, and death. With early screening and treatment, the serious effects of lead poisoning can be prevented.

It is a high priority for the state that all IHCP children between nine months and six years are tested for lead poisoning, and that children with elevated lead levels are identified and receive the recommended follow-up treatment. Children may be tested earlier than 12 months if an assessment indicates the child is at high risk for lead exposure.

3.3.2 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 Hoosier Healthwise 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

Members will receive 12-month postpartum coverage. The postpartum period begins the first day of the month following the end of the pregnancy. Members will not be disenrolled during the pregnancy and 12-month postpartum period due to any changes that would result in loss of coverage otherwise. 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 detail in the Obstetrical and Gynecological Services provider reference module.

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.

3.3.3 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 Hoosier Healthwise enrollees after review and approval by the state.

3.4 Pharmacy Benefits: Hoosier Healthwise

Prescription drugs are a benefit under the Hoosier Healthwise program to be covered by the MCE. The MCE shall support the 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 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.

3.4.1 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 8.5.

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.

3.4.2 Preferred Drug List and Formulary Requirements

The MCE shall maintain a distinct preferred drug list (PDL) for the MCE's Hoosier Healthwise packages.

The Hoosier Healthwise formulary shall support the coverage and non-coverage requirements for legend and non-legend drugs by Indiana Medicaid FFS. More information can be found in 405 IAC 5-24-3, 407 IAC 3-10-1, and 407 IAC 3-10-2. The MCE must assure that non-drug products approved for use in compounding are not subject to rebating manufacturer requirements.

Prior to implementing a PDL or formulary, the MCE shall: (i) submit the PDL or formulary to the FSSA for submission to the Drug Utilization and Review (DUR) Board; and (ii) 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 utilize 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, prior to removing one (1) or more drugs from the PDL and/or formulary or otherwise placing new restrictions on one (1) 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 in order 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 Section 3.4.5 for additional requirements on e-Prescribing. Consistent with the requirements of Section 5.7, the MCE shall develop provider education and outreach aimed at educating providers about the Hoosier Healthwise 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 utilize the state's PDL for its *Hoosier Healthwise* pharmacy benefits and to contract with the state's PBM contractor for *Hoosier Healthwise* pharmacy claims processing. If the MCE takes this approach, then the MCE shall be permitted to utilize the work of the Therapeutics Committee and DUR Board in maintaining the state's PDL for the MCE's *Hoosier Healthwise* pharmacy benefits.

3.4.3 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. For a list of the medications carved out from the MCE pharmacy benefit programs, please see the MCE contract.

Contact the FSSA pharmacy staff for a current list of the individual carved out drugs.

3.4.4 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 MCE's prescription drug programs in the Hoosier Healthwise 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 time frame 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. Please refer to the *MCE Reporting Manual* for more information on pharmacy reporting requirements.

3.4.5 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 will be required to accept prior authorization requests via telephone, fax, web-based system, or in writing. To conform to *42 CFR 437-438.3(s)* and the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F), once universal medically necessary prior authorization criteria for access to a prescription drug is developed, the MCE's criteria must be consistent with the amount, duration and scope of that criteria and may not be more stringent.

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 office of Medicaid Policy and Planning (OMPP) within 10 calendar days. Root cause analyses of any noncompliance issues are to be submitted within 10 calendar days of resolution.
- Claims processing errors
  - 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 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 one hour

3.4.6 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.

3.4.7 340B

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

The MCE must have procedures in place to exclude utilization data for drugs subject to discounts under the 340B Drug Pricing Program from the utilization reports submitted to FSSA. Specific plans for excluding utilization data should be detailed and agreed upon between the MCE and FSSA and may use tools including, but not limited to, modifiers, billing instructions, and processes to correctly identify a 340B patient.

At any given point in time, FSSA may elect to require the use of 340B-related modifiers on claims. In such an instance, the MCE shall require its providers to use the selected modifiers on their claims, and the MCE will be required to deny payment for claims that do not contain necessary modifiers.

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

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

3.5 Emergency Care

The MCEs must cover emergency services for all Hoosier Healthwise 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, seven 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*, 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*. For Hoosier Healthwise, the MCE must reimburse out-of-network providers at 100% of the Medicaid rate unless other payment arrangements are made. See the Hospital Assessment Fee module for more information.

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 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). 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 emergency department 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]() module regarding emergency room services. If a prudent layperson review determines the service was not an emergency, then the MCE must reimburse for triage services billed on a *CMS-1500* claim form. The MCE must reimburse for triage 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 emergency room utilization:

- A mechanism for a plan provider or MCE representative to respond within 1 hour to all emergency room 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 emergency room provider within one hour.
- A mechanism to track the emergency services notification to the MCE (by the emergency room 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 emergency room and to pay claims accordingly.
- A mechanism in place to document a member's referral to the emergency room by the MCE's 24-Hour Nurse Call Line and pay claims resulting from such referral as emergent.
- A mechanism and policies and procedures for conducting prudent layperson reviews within 30 days of receiving medical records.
- A mechanism and process to accept medical records for a prudent layperson review with an initial claim and after a claim has processed. For dates of service after April 1, 2020, the MCE must at a minimum allow a provider to submit medical records for a prudent layperson review within 120 days of a claim's adjudication.

3.5.1 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 emergency room providers' requests for authorization to continue post-stabilization care. MCEs must respond to these requests within one hour, 24 hours per day, seven days per week.

3.6 Behavioral Health

Behavioral health services, with the exception of Medicaid Rehabilitation Option (MRO) and *1915(i)* services, are a covered benefit under the Hoosier Healthwise 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.
- Coordinating transition of care for members going from a higher to a lower level of care.
- Coordinating transition of care to approved lower level of care for patients who are, due to lack of medical necessity, denied a higher level of care

The 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 healthcare services with Medicaid Rehabilitation Option (MRO) and *1915(i)* services and services for physical health.

3.6.1 Behavioral Healthcare Services

The MCE must provide all medically necessary community-based, partial hospital, and inpatient hospital behavioral health services as identified in Covered Services section of this policy manual and MCE Contract Exhibit 3. MCEs must pay CMHCs at no less than the Indiana Medicaid FFS rate for any covered non-MRO service that the CMHC provides to a Hoosier Healthwise member.

The MCE provides behavioral health services through hospitals, offices, clinics, in home, at school, 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 5 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.

3.6.2 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 Division of Mental Health and Addiction (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 utilize 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)
- Licensed clinical social workers
- 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 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.

3.6.3 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.

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 7 calendar days following discharge for the inpatient behavioral health hospitalization.

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

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

3.6.4 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 health care network providers notify the MCE within 5 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 the behavioral health provider to share clinical information directly with the member's PMP and the MCE to facilitate and improve coordination of the member's physical and behavioral health needs.

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.

3.6.5 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 3 business days of the missed appointment.

To facilitate the appropriate claims payment methodology, a level of care is established for members receiving Psychiatric Residential Treatment Facility (PRTF) services. PRTF providers must contact the PA vendor when an RBMC member is admitted to their facility so that the appropriate level of care is assigned. On discharge from the facility, the member is re-enrolled in the most appropriate Medicaid program.

The Mental Health and Addiction Services module provides detailed information about RBMC members admitted to PRTFs.

3.6.6 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*. See the Mental Health and Addiction Services module for billing instructions.

3.6.7 Institutions for Mental Disease

The MCE may cover short term stays in an Institution for Mental Disease (IMD) for members age 21 to 64 with an average length of stay of 30 days and maximum length of stay of 60 days.

For Indiana Health Coverage Programs (IHCP) members enrolled in Hoosier Healthwise, MCEs can authorize stays in an IMD for mental health, behavioral health and substance use disorder inpatient services under the state's 1115 waiver. The IHCP will follow the definition in accordance with 42 CFR 435.1010 for establishing eligible IMD providers. Identified IMD providers will be provided to the MCE. The Plan may not require or create incentives for the member to receive services in an IMD versus a setting covered under the State Plan.

In accordance with *42 CFR 435.1010*, an IMD "means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases." This may include a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric, or substance use disorder crisis residential services.

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.

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

The proposed services and settings will be reimbursable and subject to the requirements contained in *42 CFR part 438*.

3.7 Disease Management

The MCE must offer Hoosier Healthwise 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 Section 4: 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. For example, the diabetes disease management quarterly report will include (i) 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 (ii) 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 below. 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 serve 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.

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

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

3.7.1 Population-Based Interventions

The MCE must engage members with the conditions of interest, or the parents of children with 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 lines. 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 biannually. The MCE must document the number of members with conditions of interest, mailings, and website hits.

3.7.2 Care Management

The MCE's protocol for referring members to case 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, identification of special healthcare needs, and members with elevated blood lead levels as tested through EPSDT, must be strongly considered for case management. Case management services include direct consumer contacts to assist members with the following:

- Scheduling appointments
- Locating specialists and specialty services
- Transportation needs
- 24-hour nurse 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 case 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. Case 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 case management.

3.7.3 Case 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 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 care 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 care 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. Care 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 case 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.

3.8 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

room, 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.

3.9 Carve-outs and Related Services

Categories of service excluded from the capitation payment for an MCE's enrolled Hoosier Healthwise membership but included in the managed care benefit package are called "*carved-out*" services. While the MCE retains responsibility for the delivery and payment of most care for its members, carve-outs remain the financial responsibility of the state and are reimbursed as fee-for-service (FFS) claims under the fiscal agent contract.

Transportation services related to the carved-out services mentioned below remain the financial responsibility of the MCE. When an MCE is notified that a carve-out service is provided, the MCE can attempt to manage the care by requesting that a provider use the MCE network facilities and other ancillary providers. If the provider uses out-of-network facilities, then the MCE must reimburse the facility and ancillary providers for medically necessary services.

3.9.1 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 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. For dates of service (DOS) on or after July 1, 2019, crisis intervention, intensive outpatient treatment (IOT), and peer recovery service are removed from the list of Carved Out Services and will no longer be excluded from Managed Care. For additional information about MRO services, see the Medicaid Rehabilitation Option (MRO) Services module.

1915(i) State Plan Home- and Community-Based Services. The state has 3 1915(i) State Plan Home and Community-Based services programs: Behavioral and Primary Healthcare Coordination (BPHC), Adult Mental Health and Habilitation (AMHH) and Children's Mental Health Wraparound (CMHW). These services are carved-out of the MCEs financial responsibility. A listing of carved-out 1915Ii) services is provided in the Provider Reference Module Medicaid Rehabilitations Option Services.

Individualized Family Services Plan (IFSP) services. IFSP services provided to Hoosier Healthwise members under the FSSA First Steps program are carved-out from the MCE's responsibility.

Services rendered by provider specialty 120 – School corporation – as part of a student's individualized education plan (IEP). The MCEs must coordinate with the schools to ensure continuity of care and avoid duplication of services.

3.10 IHCP-Covered Services Excluded From Hoosier Healthwise

Broad categories of service, covered by the IHCP but excluded from managed care, are payable as FFS claims by the state fiscal agent. If a managed care member becomes eligible for any of these services, then the member is disenrolled from Hoosier Healthwise managed care. Excluded services include the following:

- *Long-term institutional care:* Package A members requiring long-term care in a nursing facility or intermediate care facility (ICF) for members with intellectual and developmental disabilities must be disenrolled from the Hoosier Healthwise 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 Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The state must then approve the PASRR request, designate the appropriate level of care in *Core*MMIS, and disenroll the member from Hoosier Healthwise.

  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 module. The MCE is responsible for payment for up to 60 calendar days for its members placed in long-term care facilities while the level of care determinations is pending. However, the MCE may obtain services for its members in a nursing-facility setting on a short-term basis, such as for fewer than 30 calendar days. This may occur if this setting is more cost-effective than other options, and the member can obtain the care and services needed in the nursing facility. The MCE may negotiate rates for reimbursing the nursing facilities for these short-term stays.

- *Hospice care:* Hospice care is not covered under the Hoosier Healthwise program; however, terminally ill members may qualify for hospice care under the fee-for-service Medicaid program after they are disenrolled from Hoosier Healthwise. The hospice provider can submit a hospice election form for the member to the IHCP Prior Authorization Unit. The IHCP Prior Authorization Unit initiates the disenrollment of the member from managed care and facilitates hospice coverage. The MCE must coordinate care for its members who are transitioning into hospice by providing to an IHCP hospice provider any information required to complete the hospice election form for the MCE's terminally ill members desiring hospice, as described in the Hospice Services module.
- *1915(c) Home and community-based waiver services:* Home and community-based waiver services are also excluded from the Hoosier Healthwise program. Similar to the situations described previously, members who have been approved for these waiver services must be disenrolled from managed care, and the MCE must coordinate care for its members who are transitioning into a HCBS waiver program until the disenrollment from Hoosier Healthwise is effective.
- *Psychiatric treatment in a state hospital:* Hoosier Healthwise members receiving psychiatric treatment in a state hospital are disenrolled from Hoosier Healthwise.
- *Psychiatric Residential Treatment Facility (PRTF) Services:* Members receiving treatment in a PRTF are not the MCE's responsibility and are disenrolled from Hoosier Healthwise. When the prior authorization vendor enters a PRTF level of care for a Hoosier Healthwise member, the managed care assignment is automatically end-dated as of the date the PRTF level of care is entered in *Core*MMIS. After the member is discharged from the PRTF and the level of care (LOC) is end-dated, the auto-assignment process immediately reassigns the member to their previous MCE with an effective date of the 15th of the month for discharges occurring on day one through day 14 of the month; or effective the first day of the following month for discharges that occur on day 15 through the last day of the month.

MCE members who qualify for long-term institutional care, hospice care, or waiver services are disenrolled from their Hoosier Healthwise managed care plans, according to the member disenrollment criteria outlined in Member Enrollment. MCEs must note that it is possible for a member's Indiana Pre-Admission Screening/Pre-Admission Screening Resident Review (IPAS/PASRR) process to be

underway (but not complete) when the member is linked to an MCE. In this situation, the financial responsibility lies with the MCE for no more than 60 days.

3.11 Short-Term Placements in Long-Term Care Facilities

MCEs may allow their enrolled members to receive services in a nursing or 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 for Hoosier Healthwise members at the IHCP FFS rate or at a rate negotiated with the facility. Refer to the following section for MCE responsibility after 30 days.

> ***Note:*** *Reimbursement for LTC facility services is not available for Hoosier Healthwise Package C members.*

3.11.1 Hospice

Hospice care is not covered under the Hoosier Healthwise program; however, terminally ill members may qualify for hospice care under the fee-for-service Medicaid program after they are disenrolled from Hoosier Healthwise. The hospice provider can submit a hospice election form for the member to the IHCP Prior Authorization Unit. The IHCP Prior Authorization Unit initiates the disenrollment of the member from managed care and facilitates hospice coverage. The MCE must coordinate care for its members who are transitioning into hospice by providing to an IHCP hospice provider any information required to complete the hospice election form for the MCE's terminally ill members desiring hospice, as described in the Hospice Services module.

3.11.2 1915(c) Home- and Community-Based Waiver Services

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

3.11.3 Psychiatric Treatment in a State Hospital

Hoosier Healthwise members receiving psychiatric treatment in a state hospital are disenrolled from Hoosier Healthwise.

3.11.4 Psychiatric Residential Treatment Facility (PRTF) Services

Members receiving treatment in a PRTF are not the MCE's responsibility and are disenrolled from Hoosier Healthwise. When the prior authorization vendor enters a PRTF level of care for a Hoosier

Healthwise member, the managed care assignment is automatically end-dated as of the date the PRTF level of care is entered in *Core*MMIS. After the member is discharged from the PRTF and the level of care (LOC) is end-dated, the auto-assignment process immediately reassigns the member to their previous MCE with an effective date of the 15th of the month for discharges occurring on day one through day 14 of the month; or effective the first day of the following month for discharges that occur on day 15 through the last day of the month.

3.12 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.
- Transitions for members who are pregnant;
- Members transitioning into the Hoosier Healthwise program from traditional fee-for-service or HIP.
- Members transitioning between MCEs, particularly during an inpatient stay.
- Members transitioning between IHCP programs
- Members exiting the Hoosier Healthwise program to receive excluded services.
- A member's transition to a new PMP;
- A member's transition to private insurance or Marketplace coverage; and
- Members transitioning to no coverage.

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 fee-for-service, the MCE must honor the previous care authorizations for a minimum of 30 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 begin 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 90 days 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.

3.13 Out-of-Network Services

With the exception of certain self-referral service providers and emergency medical care, the requirements to allow continuity of care for pregnant women transferring to the MCE in their third trimester, and members who are Presumptively Eligible and seeking initial services, 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. When 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.

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.

3.13.1 Out-of-Network Provider Reimbursement

The MCE shall reimburse any out-of-network provider's claim for authorized services provided to Hoosier Healthwise members at a rate it negotiates with the out-of-network provider, or the lesser of the following:

- The charges billed by the provider; or
- 98% of the established Indiana Medicaid FFS reimbursement rates that exist for participating IHCP providers at the time the service was rendered.

3.13.2 Extended Inpatient Hospital Stays for Children Investigated by the DCS

When there is a delay in discharge from an inpatient stay because of Department of Child Services (DCS) involvement, the extended stay days (or delay days) are reimbursed through the IHCP, rather than through the MCEs. This reimbursement is issued as a retroactive quarterly settlement, based on a settlement request form submitted to Myers & Stauffer LC by the hospital. Myers & Stauffer calculates the settlement amounts based on the information submitted by the provider and may request additional information required to complete its review, including documentation of the child's release by DCS.

In the case of claims paid by MCEs, the MCE must submit separate documentation of payment to Myers & Stauffer before the IHCP can reimburse for the extended stay days. The most recent version of the *CPS Request for Settlement* form is available on the Forms page at in.gov/medicaid/providers.com.

3.14 Hoosier Healthwise Members 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 eligibility information indicates that the patient is enrolled in Hoosier Healthwise, the LTC provider must contact the MCE identified by the Eligibility Verification System (EVS). The provider must verify the patient's IHCP eligibility, not only at admission and screening, but again on the first and 15th of every month thereafter, because the member may change from a managed health care plan to FFS Medicaid.

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. For additional information about this process, see the Long-Term Care module.

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 60 days while the LOC determination is pending.

If the provider fails to complete the paperwork for the appropriate LOC determination, and the member is still enrolled in Hoosier Healthwise then 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 60 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 Hoosier Healthwise 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.

3.15 Women, Infants and Children Infant Formula for Hoosier Healthwise Members

For Medicaid-covered nutritionals that are covered by the Women, Infants and Children (WIC) program, the MCE is **not** the payer of last resort. The MCE must not deny these types of claims in Hoosier Healthwise because the member has other insurance.

3.16 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.

The MCE may not offer gifts or incentives greater than $200 in value for each individual, and such incentives are not to exceed $300 per year per individual unless incentives in greater amounts have been approved in a manner prescribed by OMPP and such items or incentives are intended to promote the delivery of certain preventive care services. Priority incentive programs that offer gifts or incentives greater than $200 per year per individual 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, transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.)
- Enhanced tobacco cessation services
- Disease management programs or incentives beyond those required by the state
- Healthy lifestyles incentives
- Group visits with nurse educators and other patients
- Medical equipment or devices not already covered under the Hoosier Healthwise program to assist in prevention, wellness, or management of chronic conditions; and
- Cost effective supplemental services which can provide services in a less restrictive setting.

3.17 Member Financial Responsibility

3.17.1 Copayments and Cost-Sharing in Hoosier Healthwise Package C

Certain services such as emergency transportation and pharmacy may be subject to member copayments in Hoosier Healthwise Package C. Providers cannot refuse to see members based on the members' inability to pay the copayment and must accept IHCP reimbursement as payment in full for the services rendered. However, pharmacies may deny pharmacy services based on inability to pay the Package C copayment for that expense, if it is the custom and policy of that pharmacy to deny services to *any* person based on inability to pay. The pharmacy's custom and policy to deny services based on inability to pay cannot apply to IHCP members only.

There are no member copayments or cost-sharing obligations in Hoosier Healthwise Package A.

3.17.2 Charging Members for Services Rendered

In limited instances, a provider can charge IHCP members, including those in Hoosier Healthwise, for services. Services not covered by the IHCP, such as cosmetic procedures or services that have been denied through the prior authorization process, 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 receiving the services; and must be retained as documentation in the patient's medical record. See the Charging Members for Non-Covered Services section of the Provider Enrollment provider reference module for additional information about member billing.

A provider may bill a Hoosier Healthwise 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 one-year claim filing limitation.

Section 4: Member Services

The state encourages the managed care entity (MCE) to promote its plans as a solution for the entire family and must include information about Hoosier Healthwise in its marketing and outreach activities. All promotional efforts must market the MCE's Hoosier Healthwise products and services. All marketing efforts must be targeted to the general community in the 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.

4.1 Marketing and Outreach

Marketing efforts shall be targeted to the general community in the MCE's entire service area. In accordance with *42 CFR 438.104*, and the requirements outlined in Member and Potential Member Communications Review and Approval Section 4.5, the MCE shall obtain state approval for all marketing materials at least 30 calendar days prior to distribution. The MCE cannot conduct, directly or indirectly, door-to-door, telephone, email, texting, or other "cold-call" marketing enrollment practices. Cold-call marketing is defined in *42 CFR 438.104*, which addresses marketing activities, as any unsolicited personal contact by the MCE with a potential Medicaid enrollee.

The MCE may market by mail, mass media advertising (for example, radio and television), 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 shall comply with the information requirements delineated at *42 CFR 438.10* and must include the requirements and benefits of the MCE's health plans and provider network. Such materials shall be in a manner and format that is easily understood, at a fifth grade reading level and meet the general communication material requirements.

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 Hoosier Healthwise 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 at the time of application.

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.

The MCE shall submit product naming and associated domains to the OMPP for review and approval to minimize confusion for members and providers.

4.1.1 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 Hoosier Healthwise 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 Hoosier Healthwise 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.

4.2 Member Enrollment

The Division of Family Resources (DFR) is responsible for determining Indiana Health Coverage Programs (IHCP) eligibility, including for Hoosier Healthwise. 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*MMIS. Enrollee data stored in *Core*MMIS is used to confirm eligibility for various IHCP programs, including Hoosier Healthwise, during claims and capitation processing. Providers check enrollee eligibility through *Core*MMIS *via the Eligibility Verification System (EVS).*

The enrollment broker assists Hoosier Healthwise members with managed care entity (MCE) selection *if the enrollee does not select an MCE during the application process.* The enrollment broker also helps PE members select a PMP. 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.

4.2.1 New Member Materials

Within 5 calendar days of a new member's full enrollment, the MCE must send new members a Welcome Packet. 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, a copy of the member handbook including a summary of items found in the member handbook and the member's ID card.

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.

4.2.2 Health Needs Screen and Comprehensive Health Assessment

MCEs must conduct a health screening for new members who enroll in their plan. The health screening helps identify the member's physical and behavioral healthcare needs, and special healthcare needs, and identifies members who might need disease management, case management, or care management services. The health screening 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 Health Needs Screen tool (HNS). The MCE is permitted to supplement the state health-screening tool with additional questions. Any additions to the state HNS must be approved by the state. For pregnant Hoosier Healthwise members, a completed Notification of Pregnancy (NOP) form fulfills the health-screening requirement.

The MCEs are responsible for conducting 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 health screening 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.

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 Hoosier Healthwise. 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.

4.2.3 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.

4.2.4 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. The Hoosier Healthwise managed care program uses the definition and reference for children with special healthcare needs as adopted by the Maternal and Child Health Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

> *Children with special healthcare needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.*

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

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

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

In accordance with *42 CFR 438.208(c)(2)*, 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.
- 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.

4.2.5 Member Disenrollment

Hoosier Healthwise members can be disenrolled from the IHCP Hoosier Healthwise program. The following are reasons for disenrollment:

- The member was enrolled in error or because of a data-entry error.
- The member loses eligibility in the IHCP.
- The member moves out of state.
- The member becomes eligible in another Medicaid aid category.
- The member passes away.
- The member voluntarily withdraws from the program.

Examples of reasons for member disenrollment from the Hoosier Healthwise 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 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. Hoosier Healthwise members who have out-of-state addresses are systematically identified and disenrolled by the fiscal agent. Former Hoosier Healthwise members can retain IHCP eligibility during a defined notification period, as required in the *Indiana Administrative Code* (IAC). Disenrollment from Hoosier Healthwise prevents further payment of capitation during this notification period. However, members can have out-of-state designations and not be disenrolled when the DFR county staff has changed a member's address to an out-of-state location but failed to change the Indiana county code.
- 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). Package A 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 Hoosier Healthwise 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 Hoosier Healthwise. 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. 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. Hoosier Healthwise members can become eligible for HCBS waiver services. Because IHCP enrollees can participate in only one waiver program at a time, Hoosier Healthwise members who participate in another waiver program must be disenrolled from Hoosier Healthwise. MCEs that become aware of this circumstance must contact the Hoosier Healthwise Helpline at 800-889-9949 to begin the disenrollment process.
- A Hoosier Healthwise enrolled member becomes eligible for and enrolls in the IHCP Hospice Program. To receive hospice benefits, a member must elect hospice services; the attending

physician must make a certification of terminal illness; and a plan of care must be in place. When a Hoosier Healthwise member elects to enroll in the IHCP Hospice Program, the member must be disenrolled from Hoosier Healthwise, so the appropriate LOC can be entered in *Core*MMIS. The MCE's hospice analyst requests that the enrollment broker immediately disenroll the Hoosier Healthwise member. The member becomes eligible for hospice care on the managed care disenrollment effective date. This process ensures that both the MCE and the hospice providers have an accurate effective date on which to end or begin services. Hospice benefit begins the day after managed care disenrollment.

- An enrolled member who is admitted to a state psychiatric hospital is no longer eligible to participate in the Hoosier Healthwise program. MCEs are not financially responsible for any day of the member's stay for psychiatric treatment in the state hospital. The prior authorization vendor tasked with approving the PRTF PA also enters a level of care code, which systematically disenrolls the member from Hoosier Healthwise. For purposes of clarification, disenrollment only applies to Hoosier Healthwise members.
- An enrolled member who becomes eligible for Medicare is no longer eligible to participate in the Hoosier Healthwise 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.
- An enrolled member who is designated in a non-qualified immigrant status is limited to emergency services under IHCP Package E. They should not be enrolled in managed care.
- Other enrolled members as determined by the state.

4.3 Member – MCE Communications

4.3.1 Managed Care Entity Member Services Helpline

The MCE must maintain a single statewide toll-free telephone helpline staffed with trained personnel knowledgeable about the Hoosier Healthwise program equipped to handle a variety of member inquiries, including the ability to address member questions, concerns, complaints and requests for PMP changes. The same helpline shall be available to 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, 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 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.

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, and member services staff must respond to all members' messages by the end of the next business day. The MCE must provide TDD services for hearing-impaired members. If the MCE's member services helpline number or function changes, then the MCE must notify the state and the fiscal agent's managed care director about those changes.

There must also be at least one fluent Burmese speaker and one fluent Spanish speaker physically present (i.e., not via a language translation line) to answer member calls during all "live" operating hours.

Member services helpline staff must be trained in both Hoosier Healthwise program to ensure that member questions and concerns are resolved as quickly as possible. The MCE must also give their helpline staff the ability to warm transfer members directly to outside entities. This includes, but is not limited to, the enrollment broker, the DFR, provider offices, and, when appropriate, the fiscal agent.

The MCE must ensure the warm transfer of calls for members that require attention from an MCE care manager. The MCE 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
- Premium payment requirements (for Package C only)
- Required copays (for Package C only)
- Incentive programs
- Disease management services, care management and complex case management services
- Recommended age- and sex-appropriate preventive services
- Balance billing issues
- Health crises, including but not limited to suicidal callers

4.3.2 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 is 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 MCE 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 MCE'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 MCE must notify the member that the information is available in paper form without charge upon request.
- The MCE must provide, upon request, information in paper form within five (5) business days.

4.4 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)(1)*. 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 Hoosier Healthwise subpopulations (such as pregnant women, newborns, children during early childhood, at-risk members, medically frail members, and children with special needs), 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 MCE 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 MCE'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 MCE 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 MCE 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 MCE to ask for the flyer to be sent in braille, the MCE 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 MCE 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 MCE 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 MCE, 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 MCE 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 438.3(j).* 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 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)*. Please see the *Member Grievances and Appeals* section for further information about grievance, appeal and fair hearing procedures, as well as the kind of information that the MCE shall provide to members.

4.4.1 Member Handbook

The MCE must develop a member handbook for its members. The MCE's member handbook must be submitted annually for the state's review. The MCE 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(f)*. The member handbook may be offered in an electronic format as long as the MCE complies with *42 CFR 438.10(c)(6).*

The Hoosier Healthwise member handbook shall 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 benefit options
- Procedures for selecting and changing PMPs
- Information about the EPST benefit and how to access services within and outside the MCE
- The procedures for obtaining benefits provided by the state, 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 and supplies, 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(g), 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 care
- 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
- 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 4.8 for further detail regarding member rights and protections
- Responsibilities of members
- Special benefit provisions (for example, co-payments, 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

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

- Receiving poor quality of care
- Failure 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 health care needs
- Significant language or cultural barriers

- Corrective action or immediate sanctions levied against the MCE by the office 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 health care 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 6.3.3
- Related services 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
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE
- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage
- The process for submitting disenrollment requests. This information shall include the following:
- Hoosier Healthwise members may change MCEs after the first 90 calendar days of enrollment only for cause
- Members are required to exhaust the MCE's internal grievance and appeals process before requesting an MCE change
- 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. This information shall include how to obtain the enrollment broker's standardized form for requesting an MCE change
- The process by which an American Indian/ Alaska Native member may elect to opt-out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for-service benefits through the state
- 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 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 phone
- The fact that, if requested by the member and under certain circumstances: (1) benefits will continue if the member files an appeal or requests a state fair hearing within the specified time frames; and (2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.
- 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, etc.

- Information about the availability of the prior claims payment program for certain members and how to access the program administrator
- 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 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 about requesting a Hoosier Healthwise Package C (CHIP) premium recalculation of a change in income, change in family size, and so forth

4.4.2 Member Website

The MCE shall provide and maintain a website for members to access information to members through a 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 network – 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, including the 24-hour Nurse Call Line.
- Member portal with access to electronic explanation of benefits (EOB) statements. preventive care and wellness information, disease management and coordination of care services
- Information about the cost and quality of healthcare services.
- A description of the MCE's disease management programs and care coordination services
- A list of covered benefits and services by program.
- The member handbook information
- MCE distributed literature regarding all health or wellness promotion programs that are offered by MCE
- Marketing brochures and posters
- Notification letters to members regarding MCE decisions to terminate, suspend, or reduce previously authorized covered services.

- MCE-distributed literature regarding all health or wellness promotion programs offered by the MCE.
- Member's rights and responsibilities.
- Hoosier Healthwise member handbooks.
- *Health Insurance Portability and Accountability Act (HIPAA*) Notice of Privacy Practices.
- Links to the state's website for general Medicaid and Hoosier Healthwise information.
- Link to the applicable Preferred Drug Lists and pharmacy locations.
- List of all prior authorization criteria for prescription drugs, including mental health drugs
- Transportation access information.
- Information about access to carved-out services.
- Information about access to dental services and how to access the MCE's dental network
- 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.

4.4.3 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 Hoosier Healthwise members under the age of 21, this includes information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), well-child services, and blood-lead screenings. The MCE 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. 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 in the Scope of Work, under *Care Coordination*.

4.4.4 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.

4.4.5 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, in order 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 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.

4.5 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.
- In 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; refer questions about changing MCEs to the enrollment broker.
- Provide any indication about the member's eligibility; refer questions about eligibility 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.

4.6 Hoosier Healthwise Eligibility Redetermination

Hoosier Healthwise members who have gaps in Indiana Health Coverage Programs (IHCP) eligibility or managed care eligibility for more than three months are processed as new members for auto-assignment purposes. If a plan selection is not made at the time of application, the member is auto-assigned according to the auto-assignment criteria.

Members who have gaps in IHCP eligibility or managed care eligibility for less than three months are auto-assigned back to their MCE. These members are not given another 30-day free-change period.

Members who are closed at redetermination for failing to comply will have up to 90 days to provide the information that was needed and be reinstated (if passing) with no new application required.

- This does not apply if the person was closed due to eligibility factors (e.g., over income limit) rather than not providing the needed information
- Retroactive coverage can apply and if reinstated they may have no gap in coverage for the 90-day period

MCEs may assist and direct members to resources regarding the redetermination process. MCEs must offer the same level of assistance to all members (for which the redetermination date is provided) equally. Members are ultimately responsible for completing redetermination materials, signing the redetermination form, and submitting these materials to the DFR by the required deadline.

- MCEs receive notification of members who have an upcoming redetermination from the state's fiscal agent. The fiscal agent runs a monthly query for members with redetermination dates in the following month.
- MCEs must be prepared to accept calls from members requesting assistance with redetermination and must provide direction to appropriate resources to answer any questions members may have.
- MCEs may assist members in the redetermination process. Permissible examples of MCEs assisting members in the redetermination process include: Conducting outreach calls or sending letters to members reminding them to renew their eligibility in Hoosier Healthwise. All written materials and call scripts must be approved by the state before distribution.
- Directing members to applicable resources to seek further assistance with their application (for example, in.gov/fssa and FSSA/DFR Service Center).

In providing assistance during redetermination, MCEs must not do any of the following:

- Discriminate against members, particularly high-cost members.
- Provide any indication as to whether the member is redetermined eligible for Hoosier Healthwise (this decision must be made by the DFR).
- Talk to members about changing MCEs (if the member has questions, the MCE must refer the member to the enrollment broker).
- Provide incentives to members to complete or disregard their application.
- Engage in or support fraudulent activity in association with helping the member complete the redetermination process.
- Sign the member's redetermination form.

MCEs must provide redetermination assistance equally across the membership for which redetermination dates are provided and be able to demonstrate that redetermination procedures are applied consistently for each member.

Members bear the ultimate responsibility for completing redetermination materials, signing the redetermination form, and submitting it to the DFR by the required deadline.

DFR makes the final redetermination decision.

4.6.1 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 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.

4.6.1.1 Appeal Time Frame

If a member appeals within the required time frame, 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 administrative law judge (ALJ) 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. 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.

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.

4.6.1.2 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 MCEs 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.

If the member's untimely appeal is denied:

- The member's termination is final and the MCEs complete the 60 and 180 days calculations as with any termination. Penalty and debt may apply to these situations.

4.6.2 Changing Managed Care Entities Without Cause at the End of a Coverage Term

A member has an opportunity to change MCEs every 12 months during the redetermination process. At least 90 days before the end of the coverage term, the DFR sends a notice to the member about redetermination and the member's right to change MCEs during redetermination. The notice includes a statement that the request must be received by the Enrollment Broker (EB) 45 days before the end of the coverage term. This notice also includes the EB's contact information and an explanation that all requests to change MCEs must go to the EB. The EB can provide counseling regarding MCE changes.

If the member does not contact the EB to change MCEs 45 days before the end of their coverage term, the member is assigned to their original MCE. The EB will not process member requests to change MCEs without cause received less than 45 days before the end of the member's coverage term.

If the member contacts the EB and selects a new MCE, the EB must notify Core Medicaid Management Information System (*Core*MMIS), according to established procedure. *Core*MMIS processes the disenrollment with MCE #1 and enrollment with MCE #2, effective the first day of the member's new coverage term. MCE #1 must continue to provide coverage for the member until the end of the coverage term.

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 MCE) 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.

4.7 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, regardless of whether benefits for such care are provided under the Hoosier Healthwise program, 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.

4.8 Member 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 MCE shall allow members to file appeals, grievances and state fair hearing requests (after receiving notice that an adverse benefit determination is upheld). The MCE 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.

For a resident of a rural area with only one MCE, the denial of a member's request to exercise their right, under *42 CFR 438.52(b)(2)(ii)*, to obtain services outside the network (if applicable).

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 Service and Notice 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 two 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.
- The MCE must acknowledge receipt of each standard appeal within 3 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, including a phone call to the member
- In accordance to 42 CFR 438.410, 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'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.

- In accordance to *42 CFR 438.406*, 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 considered during the appeals process.
- 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). The IRO shall render a decision to uphold or reverse the MCEs decision within 72 hours for an expedited appeal, or 15 business days for a standard appeal. 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.

- 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 state 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 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
- 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
- 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.

In accordance with *42 CFR 438.424*, if the MCE or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. If the MCE or the state fair hearing officer reverses a decision to deny authorization

of services, and the member received the disputed services while the appeal was pending, the MCE shall pay for those services.

4.8.1 ***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

4.9 Oral Interpretation Services

In accordance with *42 CFR 438.10(d)*, the MCE must arrange for oral interpretation services to its members free of charge for services it provides, including, but not limited to the member services helpline described in Section 4.3.1 and 24-Hour Nurse Call Line. The MCE shall 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 discussed in Section 4.4. Oral interpretation services shall include sign language interpretation services 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.

4.10 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, 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.

4.11 MCE Application Assistance and Distribution to Nonmembers

The state permits contracted vendors in the Hoosier Healthwise 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 Program application forms.
- MCEs may not distribute:
  - State Form 48552 (7-98) Pending Verification
  - State Form 48904 (R/1-00) Application for Hoosier Healthwise for Children and Pregnant Women – Supplement
  - State Form 49154 (2-99) Request for Earnings Information for Hoosier Healthwise
  - Identity Affidavit for Children Under Age 16 Form; Change Request form
  - 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 Division of Family Resources.
- 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.

4.12 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.

   e. 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

4.13 Risk-Based Managed Care and Aid Categories

The state has sole authority for determining whether individuals meet the eligibility criteria of the Hoosier Healthwise program. The FSSA DFR makes eligibility determinations.

Enrollment in a Hoosier Healthwise managed care plan is mandatory for members in these broadly defined groups:

- Pregnancy Medicaid – Includes pregnant women at or above 138% to 208% FPL. The full scope of benefits is available to women who meet strict income criteria. Pregnancy-related coverage is provided to women who meet eligibility requirements without regard to resources.
- Children's Medicaid – Includes children who are younger than 19 years old and meet the eligibility requirements.
- Children's Health Insurance Program (Phase I expansion) – Effective July 1, 1998, includes children from 1 to 19 years old who are uninsured and otherwise ineligible for IHCP benefits, and whose family meets the eligibility requirements.
- Children's Health Insurance Program (CHIP) (Phase 2 expansion – Package C) – As of January 1, 2000, includes children from birth to 19 years old who are uninsured and otherwise ineligible for IHCP benefits, and whose families meet eligibility requirements. Unlike other categories of eligibility in Hoosier Healthwise, continued eligibility in Package C depends on payment of monthly premiums. Children are conditionally approved until the first CHIP premium payment is received. After the first CHIP premium payment is paid, members will be enrolled. The first premium payment is due the month after authorization.

The state identifies potential managed care enrollees based on the aid categories established by IEDSS. Aid categories determine the benefit packages for which enrollees are entitled. Hoosier Healthwise enrollees are eligible for one of the following four benefit packages and aid categories:

- Package A (Standard plan) –This package covers children and some pregnant women with a full range of IHCP benefits.
  - MA-X – Born to Mother on Medicaid Age: 0-1 No FPL standard.
  - MA-Y – Children younger than 1 year; income up to 208% of FPL
  - MA-Z – Children 1-5; income up to 141% of FPL
  - MA-2 – Children ages 6-18; income up to 106% of FPL
  - MA-9 – Children ages 1-5 (141-158% of FPL); 6-18 (106-158%)
  - MA-GP – Pregnancy; income above 138% FPL up to 208%
  - MA-F – Children in families, no income determination requirement for up to 12 months because of new or increased earnings of a parent or caretaker
- Package C (Children's health plan) –This package covers children younger than 19 years old in families with incomes greater than 208% but less than 250% of the FPL for emergency, preventive, primary, and acute care services. Aid category is MA-10 (K2).

4.13.1 Retroactive Eligibility

Traditional Medicaid allows retroactive eligibility in some circumstances, as determined by the DFR. *Core*MMIS receives retroactive eligibility dates, along with daily eligibility information. MCEs are not responsible for reimbursement for services provided to members during periods of retroactive eligibility, except in cases of newborns whose mothers were enrolled in the MCE at the time of birth. After enrollment in the IHCP, newborns are automatically enrolled in their mothers' MCEs, retroactive to the birth date. Several days to a few months may elapse between the birth of a newborn and the creation of a record in ICES that passes to *Core*MMIS. On payment of the premium, CHIP Package C members are eligible on the first day of the month in which the member submitted their application. If all requirements are met retroactive coverage up to three months prior to the application month are covered on a fee-for-service basis. The DFR determines retroactive eligibility.

The state requires the MCE to accept as enrolled all individuals appearing on the enrollment rosters and are financially responsible for all members for whom the MCE receive a capitation payment. Additional capitation information is located in the *Information Systems* section in this manual. Some IHCP enrollees are not eligible for the Hoosier Healthwise managed care program, even though the enrollees are in an otherwise eligible aid category. Some examples of these groups follow:

- Immigrants whose alien status is unverified and immigrants in a non-qualified immigration status who are eligible for limited IHCP benefits (Package E).
- Members who are eligible for Medicare.
- Members who have been state-approved for long-term care and the level of care has been entered into *Core*MMIS.
- Members who receive IHCP hospice care.
- Members who receive services under the Home- and Community-Based Services (HCBS) program or are residing in long term care facilities.
- Other members and potential members who are determined ineligible for Hoosier Healthwise by the state.
- Members who are admitted to a Psychiatric Residential Treatment Facility (PRTF).

- Members in these subgroups are disenrolled from the managed care program when they are identified. *Member Disenrollment* earlier in this section provides additional information about disenrollment dates.

4.13.2 Identification Cards

The MCE issues identification cards to its Hoosier Healthwise 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 Member IDs by the state when their information is first entered in the IEDSS. Member IDs, unique to each member, are randomly generated and assigned for life. The state will provide the MCE with each new Member ID for inclusion on the member identification card. The managed care entity must produce and mail the identification card to the new member within five calendar days after receiving enrollment confirmation from the state's fiscal agent. Additional information about eligibility verification is provided later in this section. The Member Eligibility and Benefit Coverage provider reference module provides detailed information about Hoosier Healthwise. A Hoosier Health Card does not guarantee current eligibility; providers must verify eligibility using the EVS before rendering services. The member information is also sent on the 834 transaction received daily by the MCEs.

Generally, providers and MCEs can verify eligibility by using the MID supplied by the member. If the member has two MIDs, they are normally linked and either MID provides the eligibility information required, and indicates the member's active MID. Occasionally, ICES 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 multiple active MIDs that have not been linked must contact the fiscal agent with the information.

MCEs must distribute their own health plan ID cards, with the state approval, to their enrolled members. However, MCEs may not require Hoosier Healthwise members to produce the MCE health plan card to receive services. MCE ID cards do not replace the IHCP Hoosier Health Card.

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 become lost or stolen, the members must contact their plan to request another ID card.

The Hoosier Healthwise card must display the following information:

- Member's name
- Member ID

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
- The Hoosier Healthwise program name and logo

Providers are responsible for verifying eligibility before rendering services. A plan identification card does not guarantee current eligibility; providers must verify eligibility using the EVS before rendering services. The member information is also sent on the 834s received daily by the plans.

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.

4.13.3 Member Enrollment

Applicants for the Hoosier Healthwise program have an opportunity to select an MCE on their application. MCEs are expected to conduct marketing and outreach efforts to raise awareness of both the 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 HHW program for a period of three (3) months or less shall be automatically reenrolled with the MCE in accordance with 42 CFR 438.56(g).

Individuals enrolled in Hoosier Healthwise have 60 days to switch MCEs after they have been enrolled, either in the MCE they selected, or in the MCE that was auto-assigned to them.

4.13.4 Member Enrollment Rosters

The state requires the MCE to accept as enrolled all individuals appearing on the enrollment rosters and are financially responsible for all members for whom the MCE receive a capitation payment. Additional capitation information is located in the *Information Systems* section in this manual. Some IHCP enrollees are not eligible for the Hoosier Healthwise managed care program, even though the enrollees are in an otherwise eligible aid category. Some examples of these groups follow:

- Immigrants whose alien status is unverified and immigrants in a non-qualified immigration status who are eligible for limited IHCP benefits (Package E).
- Members who are eligible for Medicare.
- Members who have been state-approved for long-term care and the level of care has been entered into *Core*MMIS.
- Members who receive IHCP hospice care.
- Members who receive services under the Home- and Community-Based Services (HCBS) program or are residing in long term care facilities.
- Other members and potential members who are determined ineligible for Hoosier Healthwise by the state.
- Members who are admitted to a Psychiatric Residential Treatment Facility (PRTF).
- Members in these subgroups are disenrolled from the managed care program when they are identified. *Member Disenrollment* earlier in this section provides additional information about disenrollment dates.

On behalf of the state, the fiscal agent notifies each MCE of all members enrolled in its Hoosier Healthwise 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 for both programs' rosters 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 overlap 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. The companion guides are available on the *Electronic Data Interchange (EDI) Solutions* page at in.gov/medicaid/providers.

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 twice a month list all members effective with the MCE and region as of the date the audit file was created. Hoosier Healthwise 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.

4.13.5 Hoosier Healthwise Enrollment

After IHCP eligibility has been determined or redetermined, members in eligible aid categories must enroll in Hoosier Healthwise. MCE choice is provided on the Hoosier Healthwise application. The applicant's plan selection is disregarded if the member was previously enrolled in the Right Choices Program (RCP). In this case, the member is automatically assigned to their last MCE. Potential

Hoosier Healthwise members receive program information and education from the enrollment broker by calling the Hoosier Healthwise Helpline at 800-889-9949.

Hoosier Healthwise-eligible members have 60 days from the date the member's eligibility information transfers from IEDSS to select an MCE, if they did not already select an MCE on their application. During this 60-day selection period, the EB may assist members to select their MCE. The Hoosier Healthwise Helpline representative at the EB asks the caller to confirm that the education process has been completed before entering the MCE selection in *Core*MMIS. If the potential member has not received education about the Hoosier Healthwise program, the representative provides the necessary education before taking selection information.

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.

At this time, if an MCE selection has not been entered in *Core*MMIS from the application process or via the EB, the member is auto-assigned to an MCE. Until enrolled with an MCE, Hoosier Healthwise enrollees can access medical care in the IHCP fee-for-service (FFS) program. Newborns whose mothers were enrolled in an MCE on the date of delivery are exceptions to the FFS period. Additional information about newborn enrollment is included in this section. When a member chooses an MCE but requests a change before the 1st or the 15th of the month during their 60-day open-enrollment period, the MCE selection always becomes effective on the first day of the month.

Enrollment becomes effective after a potential enrollee is linked to an MCE in *Core*MMIS. Enrollments entered in *Core*MMIS between the 11th and 25th days of the month are effective on the first day of the following month. Enrollments entered between the 26th day of a month and the 10th day of the following month are effective on the 15th day of the following month.

The MCE assignment effective date for Hoosier Healthwise members will follow the same process as the other IHCP programs. That is, the DFR identified Hoosier Healthwise 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.

4.13.6 Elements Unique to Hoosier Healthwise Enrollment Rosters

- Aid category – IEDSS-assigned designation for IHCP benefits.
- MCE assignment reasons – Numeric identifier that provides the assignment start and stop reasons that linked the member to the plan.
- Open enrollment status record – Provides the status of the member's open enrollment. O – Open, C – Closed.
- Open enrollment effective and end dates – Provides the time spans of the member's open enrollment and when MCE changes can occur.
- Auto-assignment indicator – Identifies members who were auto-assigned regardless of reason (previous MCE, case ID, default), described previously. This indicator helps the MCE identify members who were auto-assigned.
- Benefit packages – Provides the member's benefit package.
- Capitation categories – Provides the capitation categories for which the MCE is reimbursed.
- Member region – Provides the member's residence geographical region

4.13.7 *Children's Health Insurance Program Enrollment*

CHIP applicants also have the opportunity to select an MCE. For CHIP applicants, the applicant's plan selection is disregarded if the member was previously enrolled in the RCP.

For CHIP, if an MCE selection is not made on an individual's application, the individual has 14 calendar days from their eligibility effective date to contact the enrollment broker for choice counseling and another opportunity to make an MCE selection, before auto-assignment by the state fiscal agent.

Though the fiscal agent is responsible for CHIP II premium-payment processing, it is not responsible for notifying the MCEs of CHIP conditional eligibility. MCEs are notified of CHIP members via IEDSS and the 834 transaction from the fiscal agent after the member has paid their premium and the member is fully eligible.

4.14 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 Member ID. This method provides the current Member ID. Failure to verify eligibility may result in a provider rendering services to an ineligible member. All the 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.

4.14.1 *Eligibility Verification System*

The EVS consists of three interactive, real-time options:

- The Interactive Voice Response (IVR) system
- The 270/271 HIPAA-compliant eligibility inquiry and response transaction
- Provider Healthcare Portal, accessible from the home page at in.gov/medicaid/providers

After the user enters the provider identification number, applicable provider identification requirements, the member 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 Member ID, and 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, then the EVS indicates the PMP is not assigned.

4.14.1.1 Member Information Changes

The DFR is the official source of record for member demographic information. Members are required to report information changes to the Division of Family Resources (DFR) within 10 days and should do so via 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.

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 via the FSSA benefits portal:

- 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 FSSA 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 MID, 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, member ID or 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 changes and discrepancies against DFR records and verify the accuracy of the information. If the DFR cannot confirm or cannot otherwise correct the issue, the DFR will relay such to the MCE via an email response. 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. MCEs need to encourage the member to read all mail and emails received and return all requested documentation.
- 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.

> ***Note:*** *The MCE has no authority to pursue recovery against the estate of a deceased IHCP member.*

4.14.1.2 Additional Citations

IHCPPM 2220.00.00-Individuals are given 10 days to report any changes to the Division of Family Resources.

42 CF 438.608(a)(3) requires MCEs to notify the state of member address changes and date of death.

4.14.1.3 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

> ***Note:*** *The MCE has no authority to pursue recovery against the estate of a deceased IHCP member.*

4.14.1.4 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.

4.15 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.

Exceptions are subject to immediate auto-assignment and are as follows:

- Hoosier Healthwise members with less than a two-month gap and more than 90 days from the annual open enrollment period.
- Members who's PRTF 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 and Hoosier Healthwise 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.

Hoosier Healthwise-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 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.

4.16 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 health care 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).
- Take panel limits into consideration.
- Ensure provider scope of practice 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.

4.17 PMP Assignment History File From Fiscal Agent to the MCE

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. It includes assignments for PE and Hoosier Care Connect, if applicable. 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 and is not *Health Insurance Portability and Accountability Act* (HIPAA) compliant. 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 Restricted page at in.gov/medicaid/partners/managed-care-health-plans/.

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)
- For Hoosier Healthwise, the PMP assignment file captures PMP assignment history for any recipients who have a placeholder segment added during the current report cycle and whose previous MCE assignment does not match the current assignment
- 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 they were 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 (for example, the member is changing from Hoosier Care Connect to Hoosier Healthwise)
- 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 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.

4.18 Primary Medical Provider Assignments From the MCEs 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 Hoosier Healthwise PMP assignments. Files must be submitted by 6 p.m. daily, Monday through Friday. Only one file per day is processed. See PMP Assignments from MCEs for details about the file.

4.19 Changing Managed Care Entities

Hoosier Healthwise members can change health plans only at the following times:

- Anytime during their first 60 days enrolled with a new health plan; referred to as the free-change period.
- Annually during their open enrollment period.
- Anytime there is just cause.

Each Hoosier Healthwise member has 14 days after their eligibility is received from IEDSS by the fiscal agent to select an MCE following eligibility determination. If a member does not make a selection, they are auto-assigned to an MCE. Following enrollment with an MCE, in accordance with federal requirements, members maintain the right to change MCEs during their open enrollment period. Following this 60-day period, eligible members remain enrolled with the same MCE for nine months, unless they have just cause.

Just cause reasons include but are not limited to the following:

- Receiving poor quality of care.
- Failure 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 office.
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence.
- Lack of access to medically necessary services covered under the MCE's contract with the state.
- A service not covered by the MCE for moral or religious objections.
- Related services 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 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 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 office or its designee to constitute poor quality of health care coverage.

Before the member contacts the enrollment broker, the member must first contact their MCE, so the health plan can attempt to resolve the concern. If the member remains dissatisfied with the outcome,

the member can contact the enrollment broker to request disenrollment. The enrollment broker reviews the request and makes a disenrollment determination.

The enrollment broker requests a copy of the member's grievance and appeals record from the MCE. The MCE is expected to respond to the enrollment broker's request within 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).

The enrollment broker 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 MCE is expected to respond to the EB's request within three days which includes the grievance number, date filed, reason, member contact information and a summary of actions taken (including the content of the resolution). The enrollment broker makes a preliminary recommendation to the state about approving or denying the member's request. The enrollment broker must make the recommendation within seven business days of receiving the complete grievance record. The state makes the final decision.

If the member's request is approved, the enrollment broker notifies the state fiscal agent about the member's disenrollment with Plan #1, and the member's new enrollment with Plan #2. The fiscal agent processes the member's disenrollment with Plan #1 and enrollment with Plan #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 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.

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 enrollment brokers verbally or in writing after filing a grievance.

The MCE must provide the enrollment broker's contact information and explain that the member must contact the enrollment broker if the member has questions about the process. This information must include how to obtain the enrollment broker's standardized form for requesting an MCE change. 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.

4.19.1 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.*

4.20 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 60-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.

4.20.1 General Enrollment Framework

Figure 1 – General Enrollment Framework

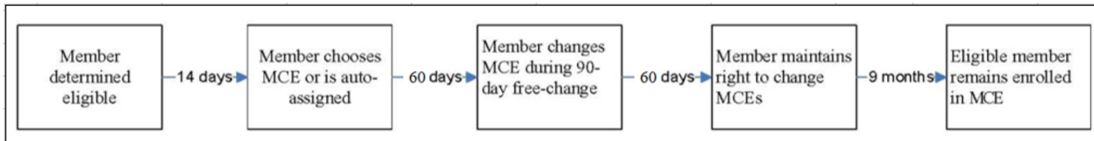
Continuing current practice, each Hoosier Healthwise member has the chance to choose an MCE on application for health coverage. If members do not choose on the application, they are auto-assigned to

an MCE the day after DFR determines the member eligible. Following enrollment with an MCE, in accordance with federal requirements, members maintain the right to change MCEs during the first 60 days of enrollment. This time frame is called the *free-change period*. Members remain enrolled with the same MCE for 12 months unless they have *just cause* (such as quality of care concerns and so forth). The 60-day free-change period and the 12-month enrollment period begin the same day.

4.20.2 Member Changes Managed Care Entities During 60-Day Free-change Period

Following enrollment with an MCE, in accordance with federal requirements, members maintain the right to change MCEs during the first 60 days of enrollment. Following this 60-day period, eligible members remain enrolled with the same MCE for nine months, unless they have "just cause."

Figure 2 – Member Changes MCEs during 60-Day Free-change Period



4.20.3 Member Changes Managed Care Entities for Just Cause

When members change MCEs for just cause, they receive another 60-day free-change period. Additionally, the member's 12-month enrollment period restarts on the date of enrollment with the new MCE.

Figure 3 – General Just Cause Timeline

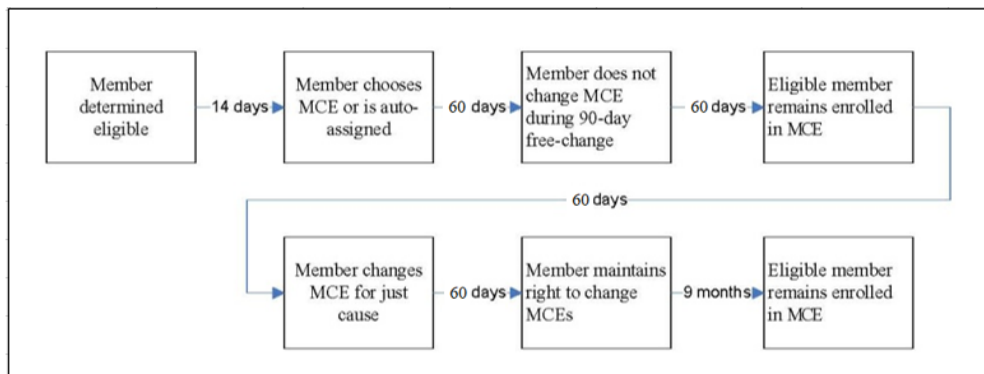
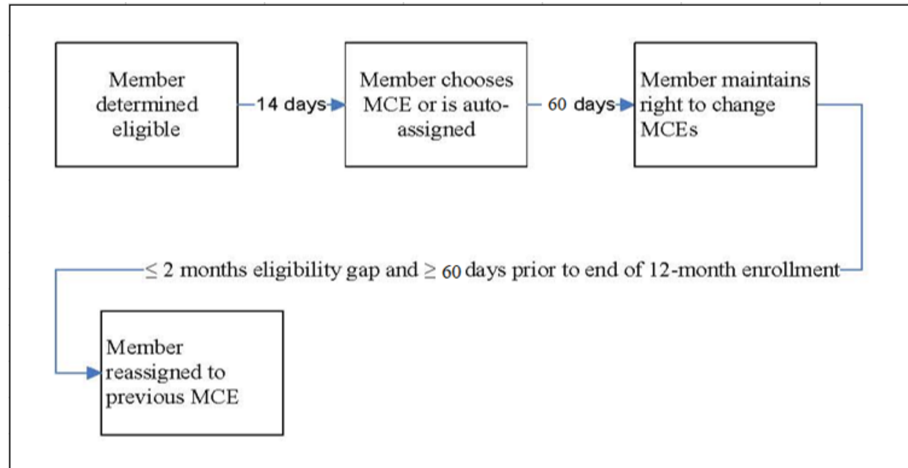
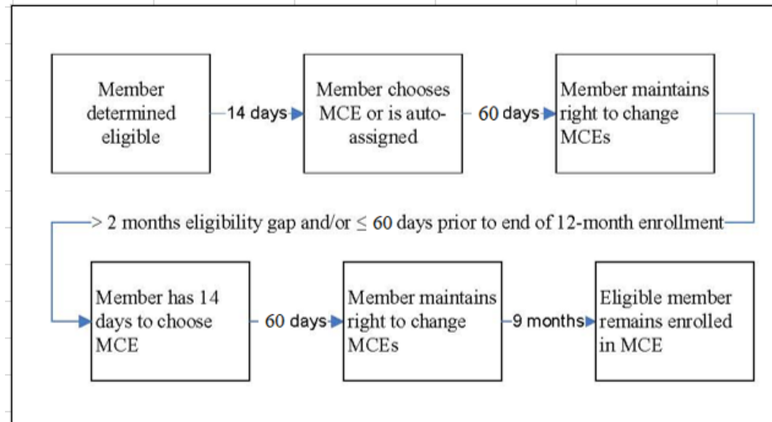


Figure 4 – Just Cause Timeline – Less than Two Months' Eligibility Gap



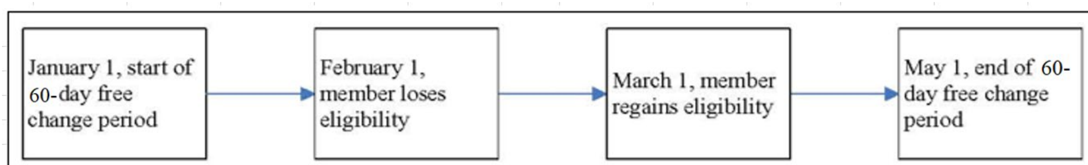
Members who have a break in eligibility greater than two months are given another 14-day choice period and are not required to return to their original MCE. This starts a new 12-month enrollment period. Members who have a break in eligibility of less than two months and regain eligibility less than 60 days before the end of their 12-month enrollment periods are also given a new 14-day choice period, 60-day free-change period, and new 12-month enrollment period.

Figure 5 – Just Cause Timeline – Greater than Two Months' Eligibility Gap



If a member loses eligibility during their 60-day free-change period, and the eligibility gap is less than two months, the member's free-change period resumes where it left off when the member regains eligibility to equal a full 90 days. In this scenario, the member is auto-assigned back to their initial MCE and has the remainder of their 60-day free-change period to maintain the right to change MCEs.

Figure 6 – Member Loses Eligibility During 60-day Free-change Period



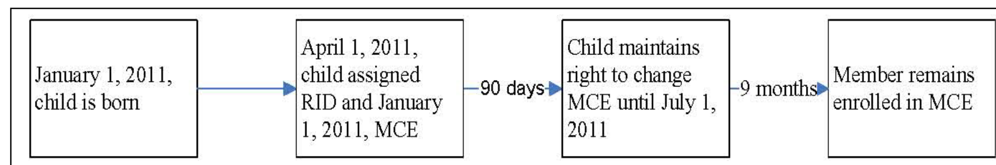
4.20.4 Exceptions to 12-Month Managed Care Entity Enrollment

If a member leaves Hoosier Healthwise and is then enrolled in Hoosier Care Connect or the Healthy Indiana Plan, and subsequently regains eligibility in Hoosier Healthwise, then the member is given another open enrollment period. The member is reassigned to the original MCE but can make a change within the first 60 days.

4.20.5 Newborn Scenario

There can be a delay in assigning newborns a Member ID. Newborns whose mothers are enrolled in Hoosier Healthwise are retro-assigned to the birthing parents' MCE to the date of birth. Because of this delay and subsequent retro-assignment, the newborn's 60-day free-change period begins the date they are assigned a Member ID, not the date of birth. *Core*MMIS accommodates both dates. In the case of newborns who are not retro-assigned to date of birth (for example, the birthing parent was not assigned to an MCE on the date of birth, or the baby is on Package C), the baby's free-change period begins on the date of enrollment with the MCE, the same as any other member.

Figure 7 – Newborn Scenario



4.20.6 Family Member Free-Change Periods

Members of the same family often have different eligibility effective dates. The family members also have different enrollment time frames. The free-change periods within a family do not coincide and could potentially enroll family members in different MCEs, requiring families to call multiple times throughout the year to change MCEs during each family member's free-change period. Families can avoid this by opting to change additional family members' MCE enrollment when one family member is in a free-change period. Family member relationships are confirmed by the case ID provided by IEDSS and stored in *Core*MMIS.

4.21 Presumptive Eligibility (PE)

Presumptive eligibility provides immediate, temporary coverage for certain groups of individuals who are likely to be eligible Medicaid coverage.

Hoosier Healthwise aid categories eligible for PE include low-income children at or below 158% FPL.

All the aforementioned individuals are placed into the fee-for-service program during their presumptive eligibility period.

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.

4.22 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.

4.22.1 Portal Recognized Providers for Notification of Pregnancy

To submit and receive payment for an NOP, the Hoosier Healthwise risk-based managed care (RBMC) pregnant member must be assigned to one of the MCEs. Providers must be enrolled with the IHCP in one of the following specialties submit and be reimbursed for the completion of the NOP form:

- Family or general practitioner
- General Pediatrician
- General Internist
- Obstetrician or gynecologist
- Neonatologist
- Certified nurse midwife
- Advanced practice nurse practitioner
- Federally qualified health center
- Medical clinic
- Rural health clinic
- Acute care hospital
- County health department
- Family planning clinic
- Nurse practitioner clinic

4.22.2 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 woman 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). MCEs use the NOP data to determine the health risk level associated with the woman'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.

4.22.2.1 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. The NOP form is available on the MCO Question and Answer page at indianamedicaid.com under *Project Documentation/Notification of Pregnancy Documentation*. 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:

- Person completing the form
- Date of service
- 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)
- Physician name (prepopulates when completed through the Portal)
- Physician telephone (prepopulates when completed through the Portal)
- NPI/ Provider ID (prepopulates when completed through the Portal)
- Delivery system (prepopulates when completed through the Portal)
- Date last menstrual period (LMP)
- Estimated date of confinement (EDC)
- Current tobacco user
- Other risk indicators
- Obstetrical history

- Medical history/exam
- Mental health
- Substance abuse
- Environmental/social

Section 1: Maternal Obstetrical History – Conditions identified in this pregnancy and past pregnancies must be checked in this section. If no current or historical conditions apply, the recognized provider must select *If none above apply, please check here.* This section is a required field.

The following question must also be answered in Section 1: *< 12 months between births Yes/No.* The system does not allow the user to continue if the provider has left this question unanswered.

Section 2: Previous Infant/Findings – This section refers to the history of birth outcomes a member may have had with previous pregnancies. This section may not apply to all members. Please check all relevant birth outcomes the woman experienced with any of her previous pregnancies.

Section 3: Maternal Medical History – Conditions identified in this pregnancy and past medical history must be checked in this section. If no current or historical conditions apply, the recognized provider must select *If none above apply, please check here.* This section is a required field.

The following questions must be answered in Section 3:

- *HIV/AIDS tested Yes/No*. The system does not allow the user to continue if the recognized provider has left this question unanswered.
- *ER or hospitalization in last 6 mos. Yes/No* and *If yes, how many?* The system does not allow the user to continue if the recognized provider has left this question unanswered.
- Section 4: List All Current Medications – List all current medication. This is an open field that allows the recognized provider to list as much detail as necessary. If no medications are entered, the provider must choose None, or the system does not allow the completion of the NOP.
- Section 5: Psycho-Neurological History – If the member has a condition that applies to this section, the diagnosis must be checked. If there are no current or historical conditions to report, the recognized provider must select *If none above apply, please check here.*
- Section 6: Substance Abuse/Use History – If the member is currently using or has a history of substance abuse and use, this must be indicated in this section. If there is no current or historical use, the recognized provider must select *If none above apply, please check here.*
- Section 7: Tobacco History – If the member is currently using cigarettes or tobacco, or has a history of use, this must be indicated in this section. The system does not allow the user to continue if the recognized provider has left this question unanswered.
- Section 8: Social Risk Factors – Social risk factors often lead to referrals for support services outside the recognized provider's office. If the member does not identify social risk factors from the list, the recognized provider must select *If none above apply, please check here.*
- Section 9: Diagnosis of Pregnancy Risk – The recognized provider must determine the diagnosis of pregnancy risk as a Normal Pregnancy or a High Risk Pregnancy. The provider must also indicate Gravida and Para and must list any other medical or psychological problems not addressed elsewhere on the form.
- Section 10: Referrals – Recognized providers are encouraged to identify services to which the pregnant woman was referred. This better prepares the MCEs to follow up with women about these referrals.

4.22.2.2 State-Approved Training Documents and Forms

Other NOP state-approved training documents and instructions are also found on in.gov/medicaid/providers.

4.22.2.3 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 – 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 following codes are included in the NOP data extract and provide an explanation of the reasons an NOP is considered not valid or suspect:

- S01 Miscarriage
- S02 Abortion
- S03 Pre-Term Del
- I01 Duplicate
- I02 > 5 days DOS
- I03 > 30 wks. Gest

The system specifications and fields for this data extract, process flowchart, and schema XML format are available 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.

4.22.2.4 NOP Data Extract Risk Level Update File from MCEs to the Fiscal Agent

After the MCEs receive 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)

- Risk Level

The MCE receives an error message if the file returned to the fiscal agent does not contain a risk level or if the file is not in the correct format:

- Date Received
- XML Valid – True/false
- Error Message – If the XML format is not valid
- Number of total updates on the file
- Number of accepted updates
- Number of rejected updates

NOP information for each NOP update attempted verifies the following data:

- Identification number
- Success – True/false
- Error Message – If the NOP update was not successful
  - S01 = Miscarriage
  - S02 = Abortion
  - S03 = Pre-Term Del
  - I01 = Duplicate
  - I02 = > 5 days DOS
  - I03 = > 30 wks. Gest

4.22.2.5 Provider Billing Guidelines

NOP information must be submitted via the Portal for the recognized provider to receive reimbursement for completing the NOP form.

Billing guidelines for NOP are as follows:

- NOP can only be billed for a Hoosier Healthwise/RBMC-enrolled member 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 member.
- NOPs for pregnant members with gestations of 30 weeks or more are not eligible for $60 reimbursement.
- NOPs completed for traditional fee-for-service members are not eligible for $60 reimbursement.
- Recognized providers that complete a NOP on a PE member must allow 24 hours from the assignment date of the PE MID to submit an NOP via the Portal. The 24-hour time frame allows the EVS time to accurately display the PE member data.

4.22.2.6 High-risk Pregnancy Payment and NOP

To document medically high-risk pregnancies for Hoosier Healthwise 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, the provider must complete an NOP for the High Risk Modifier to be paid. As previously mentioned, NOPs completed after 30 weeks cannot receive the $60 reimbursement. Also, for those who already have the NOP 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.

4.22.2.7 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 codes of NP (Package A) or CP (Package C). 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 five calendar days from the date of service.
- The NOP was submitted by the recognized provider for a member 30 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.

4.22.3 Newborn Prebirth Selection

Pregnant members' MCEs coordinate PMP preselections for newborn members. *Core*MMIS retroactively assigns newborns to their respective birthing parents' 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.

4.22.4 Provider-Initiated Requests for Member Reassignment

The Hoosier Healthwise programs encourage 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.

The following, developed and finalized by the Hoosier Healthwise Quality Improvement Committee (QIC), provides guidelines for situations outlined previously:

- 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. Hoosier Healthwise members are not penalized for an inability to leave work, for lack of transportation, or for other defensible reasons. 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 Hoosier Healthwise 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 be documented as to 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 room 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.
- Non-compliance 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 Hoosier Healthwise enrollment – PMPs may not initiate member transfer requests because of unpaid medical bills incurred before Hoosier Healthwise enrollment. PMPs can pursue charges outstanding before Hoosier Healthwise enrollment through the normal collection process.

Section 5: Provider Network Requirements

Managed care entities (MCEs) contracting with the Family and Social Services Administration (FSSA) to administer the Hoosier Healthwise 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' Hoosier Healthwise programs.

5.1 Network Development

The state requires the MCE to develop and maintain a comprehensive network to provide services to its Hoosier Healthwise members. The network must include providers serving special needs populations. For its Hoosier Healthwise population, the network must include providers serving children with special healthcare needs.

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 Hoosier Healthwise 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; 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 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.

5.2 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.
- 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.

5.2.1 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 home 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.

5.2.2 Primary Medical Provider (PMP) Requirements

Providers may contract as a 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-Hoosier Healthwise members (such as commercial, traditional Medicaid 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. In Hoosier Healthwise, a referral from the member's PMP is required when the member receives physician services from any provider other than their PMP, unless the service is a self-referral service.

The state requires the MCE to provide access to PMPs within at least 30 miles of the member's residence. Providers that may serve as PMPs include the following:

- Internal medicine physicians
- General practitioners
- Family medicine physicians
- Pediatricians
- Obstetricians
- Gynecologists
- Endocrinologists (if primarily engaged in internal medicine)
- Advance practice registered nurses (APRN)
- Physician extenders

The MCE's PMP contract must state the PMP panel size limits, and the MCE must assess the PMP's non- Hoosier Healthwise 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- Hoosier Healthwise practice to ensure that the PMP's Hoosier Healthwise population is receiving accessible services on an equal basis with the PMP's non- Hoosier Healthwise 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.

5.2.2.1 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 Hoosier Healthwise 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.

5.2.3 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 1 – Network Specialty Providers

Specialties	Ancillary Providers
• Anesthesiologists* • Cardiologists* • Cardiothoracic surgeons** • Dentists/Oral Surgeons* • Dermatologists** • Endocrinologists* • 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*	• Diagnostic testing* • Durable Medical Equipment providers • Home Health • Prosthetic suppliers**

Specialties	Ancillary Providers
• 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.
- 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.

5.2.4 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.

5.2.5 Non-Psychiatrist, Non-SUD Behavioral Health Providers

MCEs must establish a network that includes psychiatrists and other behavioral health providers, addressing both 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 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 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 home.
- In rural areas, the MCE must provide at least one behavioral health provider within 45 minutes or 45 miles. 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)
- Certified social workers
- 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

5.2.6 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 home 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.

5.2.7 SUD Providers

The MCE 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 MCE is encouraged to contract with all available SUD treatment providers. The MCE must include a network of providers who are authorized to provide medication-assisted treatment (MAT), including buprenorphine.

The MCE shall ensure the availability of a MAT provider within thirty (30) miles of the member's residence.

5.2.8 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 services 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.

5.2.9 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
- 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.

5.2.10 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 Hoosier Healthwise 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 Hoosier Healthwise line of business. The report must be completed in the form and manner set forth in the *MCE Reporting Manual*. For Hoosier Healthwise, the data must be submitted on an incurred-claims basis, including separate reporting of Package A/P FFS claims, Package A/P capitation claims, Package C FFS claims, and Package C capitation claims. The state reserves the right to require Hoosier Healthwise data to 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 taxpayer 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.

5.2.11 School-Based Clinics

Some Hoosier Healthwise members are eligible for and receive medical services in a school-based clinic. These clinics typically have funding sources other than the IHCP, and do not bill the IHCP for the services they provide. For school-based clinics to bill for services provided to Hoosier Healthwise enrollees, the clinics must be IHCP-enrolled providers. Clinics that expect reimbursement from an MCE in the Hoosier Healthwise program must be IHCP-enrolled providers and must obtain MCE authorization before providing services. Services provided in a school-based clinic are usually limited to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), immunizations, first aid, family planning counseling and services, prenatal and postpartum care, dental services, behavioral health services, drug and alcohol abuse counseling, patient education or other primary care and preventive services.

For dates of service on or after July 1, 2023, IHCP has expanded the mandated federal and state educational plans that can authorize coverage of medically necessary school-based Medicaid services. Reimbursement is available for medically necessary mandated school-based services when provided pursuant to a Medicaid-enrolled student's educational program or plan as required by the Individuals with Disabilities Education Act (IDEA) or §504 of the federal Rehabilitation Act of 1973 (29 USC §794). Please refer to the IHCP Bulletins page for more information on plans. Billing instructions are

the same as listed for IEP services. Services for mandated education plans are carved out and adjudicated as fee-for-service.

School corporations can also provide IHCP-covered services to students as part of an individualized education plan (IEP). All claims for services provided to Hoosier Healthwise members as part of an IEP that are billed by provider specialty 120 – school corporation are carved out of the MCE capitation rate and adjudicated as fee-for-service (FFS) claims by the fiscal agent. The provider must send these claims to the fiscal agent, not to the MCE.

The state strongly encourages MCEs to collaborate with school-based programs in the delivery of care to their members and to encourage their PMPs to assist in the coordination of medical services

5.2.12 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 MCE shall offer to enter into contracts with Indian health care providers participating in Medicaid that reflect the provisions in this Section.

Access to Indian Healthcare Providers

In accordance with section 5006(d) of ARRA, the MCE 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 MCE'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 MCE 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 MCE, 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 MCE 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.

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 MCE 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.

Tribal Assessments and Care Plans

The MCE 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 MCE's network. This applies to services requested by AI/AN enrollees residing on or off tribal land.

Tribal Training and Orientation

The MCE shall provide training and orientation materials to tribal governments upon request and shall make available training and orientation for any interested tribal governments.

Payment for Indian Healthcare Providers

In accordance with section 5006(d) of ARRA, the MCE 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 MCE 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).
- 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).
- 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.
- 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 MCE 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 MCE to make a supplemental payment to an Indian healthcare provider, the MCE shall provide the requested data within thirty (30) calendar days of the request.

Cooperation

The MCE 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 MCE.

5.2.13 County Health Departments

FSSA 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.

5.2.14 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 immediate care clinics, including retail clinics. The state will continue to monitor the MCE's access to primary and urgent care.

5.2.14 Dialysis Treatment Center

The MCE shall ensure the availability of one dialysis treatment center within sixty (60) miles of the member's residence.

5.2.15 OB/GYNs

The MCE shall establish a network of OB/GYNs for women's healthcare and maternity needs. The MCE 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 reserves the right to change this requirement at any time in accordance with Contract Section 2.10.

5.2.16 Non-emergency Medical Transportation Providers

In accordance with 42 CFR 440.170 the MCE shall provide an appropriate means of NEMT for individuals, who have no other means or transportation available, and addresses the safety needs of the person with disabilities and/or special needs.

5.3 Provider 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 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. Under the terms of the provider services agreement, the provider must agree that the applicable terms and conditions set out in the *Hoosier Healthwise 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 *Hoosier Healthwise 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 PE pregnant women and newborns.
- Require each provider to use the *Indiana Health Coverage Program Prior Authorization Request Form*, available IN.gov/Medicaid, 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 Hoosier Healthwise 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 Hoosier Healthwise 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 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 Package C 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 non-contracted providers outlined in *405 IAC 1-1.6-1*.

5.4 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 program.

The MCE must use the IHCP MCE Practitioner Enrollment form, the IHCP MCE Hospital/Ancillary Enrollment form or gather the information identified on the forms during the provider network participation request 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 Ac*t. The MCE must notify the state of any credentialing applications that are denied because of program integrity-related issues.

5.4.1 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 they are 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.

As outlined in the Provider Network Participation Request section, 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 information must be communicated with providers via the MCE website and in direct correspondence with providers.

The MCE must 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 must 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.

5.4.2 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.

5.4.3 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.

5.4.4 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:

1. Member complaints
2. Quality reviews (practice-specific)
3. Utilization management (profile of utilization)
4. Member satisfaction (practice-specific)
5. Medical record review
6. 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.

5.4.5 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.

5.4.6 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.

5.4.7 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.

5.4.8 Clinical Laboratory Improvement Amendments

MCEs must arrange for laboratory services only through laboratories with current CLIA certificates.

5.5 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 *42C.F.R.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).

5.6 Provider Education and Outreach Activities

The MCE must provide ongoing education to its provider network on the Hoosier Healthwise programs, 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.

> ***Note:** 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.*

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 3 business days of distribution. The provider communication materials must be organized online in a user-friendly, searchable format by communication type and subject.

5.6.1 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 Hoosier Healthwise 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 line 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 MCE in writing of the reason for the overpayment per 42 CFR 438.608(d)(2)
- Policies and procedures for member grievances, appeals, 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)
- 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.

5.6.2 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. All state approved provider communication materials shall be available on the MCE's provider website within three (3) business days of distribution. 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 Hoosier Healthwise 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 room 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 Hoosier Healthwise information
- A link to the state's Preferred Drug List (Hoosier Healthwise only)
- 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.

5.6.3 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 OMPP 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.*

5.6.4 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.

5.6.5 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.

5.6.5.1 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>.

5.7 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 from in.gov/medicaid/providers.

5.7.1 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. 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 prior authorization 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, Illinois (the following counties)
  - Cook
  - Dekalb
  - DuPage
  - Grundy
  - Kane
  - Kendall
  - Lake
  - McHenry
  - Will
- Cincinnati, Ohio (the following counties)
  - Boone
  - Bracken
  - Brown
  - Butler
  - Campbell
  - Clermont
  - Gallatin
  - Grant
  - Hamilton
  - Kenton
  - Pendleton
  - Warren
- Louisville, Kentucky (the following counties)
  - Bullitt
  - Henry
  - Jefferson
  - Oldham
  - Shelby
  - Spencer
  - Trimble
- Evansville, Indiana (the following county)
  - Henderson (KY)
- South Bend, Indiana (the following county)
  - Cass (MI)

Additionally, the FSSA allows newly enrolling providers that are located out-of-state (not in one of the aforementioned counties) to request in-state status when applying for IHCP enrollment. Providers may qualify for in-state status based upon one of the following circumstances:

- Enrollment increases access to medically necessary services in areas where the distance to an in-state provider would subject a member, or a member's family, to significant financial hardship or create an unnecessary significant burden on a member.

- Enrollment allows a member to retain a primary medical provider, or to obtain specialty services from a provider (such as centers for excellence) when the same care may not be available from an in-state provider or would place a significant hardship on a member due to the geographic location of the in-state specialty care provider.
- Transportation to an appropriate in-state provider would cause significant undue expense or hardship on a member or the office.
- Enrollment addresses an emergency health crisis.
- Durable medical equipment and home medical equipment providers are allowed to request in-state status by answering yes to all of the following questions:
  - Do you maintain an Indiana business office, staffed during regular business hours, with telephone service?
  - Do you provide service, maintenance, and replacements for IHCP members whose equipment has malfunctioned?
  - Do you qualify with the Indiana Secretary of State as a foreign corporation?
  - Do you anticipate at least 70% of your Indiana business to be rendered by mail order or online purchases?

5.7.2 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 Hoosier Healthwise 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 Hoosier Healthwise 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.

5.7.3 Presumptive Eligibility Qualified Provider Enrollment

Information regarding the PE program and QP enrollment can be found in the Presumptive Eligibility section in this manual. Specific QP enrollment processes are outlined in the Presumptive Eligibility and Presumptive Eligibility for Pregnant Women provider reference modules on the Provider Reference Materials page at in.gov/medicaid/providers.

5.7.4 Pre-Enrollment Provider Education

The MCEs can educate physicians interested in becoming PMPs about the Hoosier Healthwise 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:

- Hoosier Healthwise 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 Hoosier Healthwise.
- 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 from indianamedicaid.com.*

5.7.5 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.
- IHCP-covered but MCE-excluded services – This information is described in IHCP-Covered Services Excluded from Hoosier Healthwise.
- 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 the Quality Improvement and Utilization Management section of this manual
- Billing requirements
- Eligibility issues
- Preventive health standards and requirements (including EPSDT)

- Encounter data requirements as described in the Information Systems section of this manual
- Reassignment of a member to another PMP – This process, as initiated by the provider, is described in the Member Enrollment section of this manual

5.8 Hospital Assessment Fee

Hospital Assessment Fee (HAF) payments are integrated into capitation rates. MCEs are required to pay HAF hospitals at the enhanced Medicaid rates for the following HAF eligible services:

- HAF eligible hospitals
- Contracted providers: MCEs shall pay 100% of the enhanced (HAF) rates, which is 100% of the fee schedule rate multiplied by the HAF factor OR 100% of the Inpatient APR DRG rate multiplied by the HAF factor.
- Noncontracted providers: MCEs shall pay 98% of the enhanced (HAF) rates, which is 98% of the fee schedule rate multiplied by the HAF factor OR 98% of the Inpatient APR DRG rate multiplied by the HAF factor.

5.9 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. The username is MCEhealthplans. This site is password protected. MCEs can obtain the password by contacting their OMPP Contract Manager. A copy of the *MCE Enrollment Form* is found in *Appendix C.* The MCEs must submit the form to the fiscal agent's Managed Care 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.

If the MCE has network contracts in Hoosier Healthwise, the MCE is required to complete Hoosier Healthwise *MCE Enrollment Addendum*s for each region and submit them to the state for approval. The state forwards the network information 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. The numeric region identifiers for Hoosier Healthwise are listed in the following table.

Table 1 – Hoosier Healthwise Region Identifiers

Region Identifier	Region Name
1	Northwest

Region Identifier	Region Name
2	North Central
3	Northeast
4	West Central
5	Central
6	East Central
7	Southwest
8	Southeast
9	Out of state/FSSA

5.10 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
- 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 health care 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.

5.11 Provider Network Participation Requests

5.11.1 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.

5.11.2 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.

5.11.3 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. 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 or contract execution as outlined in 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 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 some cases, the effective date may 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 should be used for network participation requests received on or after Jan. 1, 2022.

5.11.3.1 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.

5.11.4 Provider Network Participation Documentation

5.11.4.1 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 January 1, 2022.

5.11.4.2 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.

5.11.5 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.

5.11.5.1 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 two 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.

5.12 Provider Enrollment

The MCE components of Hoosier Healthwise 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 Hoosier Healthwise programs.
- 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 Hoosier Healthwise 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 Hoosier Healthwise, MCEs must ensure that members continue to receive care for a minimum of 30 calendar days.
- When a PMP disenrolls from the Hoosier Healthwise 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.

5.12.1 Indiana Health Coverage Programs Provider Enrollment Processing

To participate as a PMP or specialist in the Hoosier Healthwise 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.

There are two types of IHCP providers:

- Billing providers (sole proprietorship, group)
  - A sole proprietorship is a provider that owns a practice location where they are the sole practitioner performing services with an unshared taxpayer identification number (TIN).
  - A group is a business entity that owns one or more service locations where providers are employed or contracted to perform professional services on behalf of the business entity.
- Group members (rendering providers)
  - A group member is a rendering provider that is employed or contracted to render services to IHCP members. Group members cannot have a billing service location in *Core*MMIS. All services are billed using the group's ID number.

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 claim processing. It is the MCE's responsibility to ensure that any network providers delivering services to members in the Hoosier Healthwise program are enrolled as IHCP providers. Providers enroll initially by completing the *Indiana Health Coverage Programs Provider Agreement* and mailing it to:

Gainwell 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 on the Provider Reference Materials page at in.gov/medicaid/providers. Providers may also contact the fiscal agent's Provider Enrollment by telephone at 877-707-5750 to request enrollment applications and to get answers to questions about IHCP provider enrollment.

5.12.2 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 G. The file layouts are posted to the MCE Secure Landing page at in.gov/medicaid/partners.

5.12.3 Managed Care Entity Preferred Medical Provider Enrollments and Updates

MCEs can submit individual PMP enrollments for their Hoosier Healthwise plans 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*.

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.

5.12.4 Linking Preferred Medical Providers to Managed Care Entity Networks

As of April 2011, all MCEs have the capability to establish PMP networks for the Hoosier Healthwise program and enroll their PMPs accordingly in the Portal. MCEs also have the ability to disenroll their PMPs from networks using the Portal.

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.

5.13 Changes to Preferred 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.

On receipt of a change request from a PMP, the MCE can perform a change through the *Portal* > *Provider Profile*: *Update a PMP*. If the Portal is not available, the MCE can submit the *MCE Network PMP Panel Size/Panel Hold Request Form* to the fiscal agent PMP enrollment specialist, who updates the PMP's record in *Core*MMIS.

5.14 Provider Disenrollment

A PMP can be disenrolled from the Hoosier Healthwise 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 Hoosier Healthwise 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.

5.14.1 Steps for Disenrolling a Preferred Medical Provider

The following are steps for disenrolling a PMP from an MCE:

1. Log into Access the Portal.
2. Click **Provider Profile**. A new selection appears under the Managed Care section, titled Disenroll a PMP.
3. Click **Disenroll a PMP**. A new page appears, titled PMP Disenrollment.
4. Search for the desired provider location by entering the PMP's group or NPI or Provider ID and the MCE ID.
5. Click **Select Service Location**. A new page appears; all service locations for the group are selected.
6. Select the disenrolling PMP using the radio buttons.
7. Type the effective date of disenrollment and choose the disenrollment reason from the drop-down list. Disenrollment reasons are as follows:
   a. PMP no longer practices at this location
   b. PMP no longer contracted with MCE
   c. PMP no longer in managed care at this location
   d. PMP deceased
8. The date must be the current date or a future date except for death of PMP. Web editing prevents entry of a past date except when the reason code is *PMP Deceased*.

9. Click **Save** and **Close** to complete the process.

5.15 IHCP Disenrollment and Preferred 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 five 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 Managed Care 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.

5.16 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 non-contracted 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.

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.

5.17 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.

5.18 Practice Standards

5.18.1 Universally Accepted Practice Standards

There must be evidence that the MCE further enhances quality of service to its Hoosier Healthwise 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 the Hoosier Healthwise 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 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.*

5.19 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 claim 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.

5.19.1 Interest Payments to Non-Contracted Providers

MCEs are financially responsible for interest payments on clean claims billed by providers. The requirement ensures timely payment of claims for services provided to Hoosier Healthwise enrollees. Interest is payable in accordance with provisions set forth in *IC 12-15-13*.

5.19.2 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 Review Module 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 non-covered 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 non-covered.
- 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 filing limit established by the MCE.
- 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:

- The provider must establish that authorization has been requested and denied before rendering the service.
- 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.
- 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.
- 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.
- 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 non-covered 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.

5.19.3 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.*

5.19.4 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*.

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.

5.19.5 School-Based Healthcare Services

MCEs must plan for, develop, and enhance relationships with school-based health centers (SBHCs) with the goal of providing accessible quality preventive and primary healthcare services to school-aged Hoosier Healthwise members.

An SBHC is a health center located in a school or on school grounds that provides on-site comprehensive preventive and primary health services, including behavioral health, oral health, ancillary, and enabling services. These services may include a wide variety of preventive services, including general health screening or assessments, EPSDT screenings, laboratory and diagnostic screenings, immunizations, first aid, family planning counseling and services, prenatal and postpartum care, dental services, behavioral health services, drug and alcohol abuse counseling, patient education, and other services based on the student's need and on the philosophy of the school administration.

On-site healthcare providers at SBHCs generally include a nurse practitioner or physician assistant who operates under the standing orders of a physician, a consultant physician, and a clinically trained behavioral health practitioner.

SBHCs have varying capacities and resources to deliver healthcare. For purposes of this procurement, SBHCs are not permitted to serve as PMPs. However, MCEs are encouraged to be creative in their approaches to collaborating with SBHCs, and to begin to develop affiliations with SBHCs with the potential of expanding those affiliations and the scope of services available in SBHCs in the future. The following are some examples of the types and levels of services acceptable in SBHCs:

- The SBHC coordinates care with the child's PMP, who assumes responsibility for care whenever the SBHC closes. The SBHC can deliver preventive and primary medical care but may rely on its partner for year-round accessibility and 24-hour-a-day coverage.
- The SBHC provides a limited range of services. For example, the SBHC may be able to provide services such as preventive medical care, health education, reproductive healthcare, behavioral health services, dental services, and immunizations, and may also have limited hours of operation.
- The SBHC refers the child back to their PMP for the majority of their primary care.

MCEs' relationships with SBHCs vary, depending on the resources available in MCEs' area. The following list includes examples of possible MCE relationships with Indiana SBHCs, not requirements for the Hoosier Healthwise program:

- FQHCs, health systems, or other organizations contracted with an MCE may sponsor an SBHC. The MCE reimburses the sponsoring organization, which reimburses the SBHC for care provided to members enrolled in the MCE.
- An MCE can include SBHCs in its provider network. The MCE reimburses the SBHC for care provided to members enrolled in the MCE.
- MCEs may allow members to self-refer to an SBHC; for example, for a prescribed set of acute care visits, MCEs can reimburse SBHCs on a fee-for-service basis. The primary care functions and reimbursement stay with the child's PMP, but the SBHC serves as an acute care provider.
- The SBHC can function as a satellite office for existing contracted providers.
- MCEs can reimburse an SBHC for care provided to enrolled members as an out of network provider.
- To avoid duplicate services, promote continuity of care, and develop strong relationships between SBHCs and PMPs, the SBHC must coordinate care and refer children to their PMPs for follow-up.

5.19.6 Direct Payment for Eligible Out-of-State Children's Hospitals

The MCE is required to reimburse inpatient hospital and outpatient hospital services provided by eligible out-of-state children's hospitals at one hundred thirty percent (130%) of the Medicaid reimbursement rate. This applies to claims for Hoosier Healthwise members that are less than 19 years of age. This reimbursement requirement is effective July 1, 2021, through June 30, 2023, in accordance with House Enrolled Act (HEA) 1305.

Eligible out-of-state children's hospitals are children's hospitals located in a state that borders Indiana. In addition, the out-of-state children's hospital must be a freestanding general acute care hospital, or a facility located within a freestanding general acute care hospital that is:

- Designated by the Medicare program as a children's hospital; or
- Furnishes inpatient and outpatient health care services to patients who are predominantly individuals less than 19 years of age

If a hospital meets the requirements of HEA 1305 and has not been contacted by the IHCP, the MCE shall contact Myers and Stauffer LC via email at INHospital@mslc.com. If a hospital does not meet the requirements of HEA 1305, the hospital is not eligible for this reimbursement program and shall be paid at the out-of-network reimbursement rate. In-state children's hospitals residing within Indiana are not eligible for this reimbursement program as they should be paid using the Hospital Assessment Fee factor.

The MCE shall reimburse eligible out-of-state children's hospitals at one hundred thirty percent (130%) of the Medicaid increased reimbursement rate except for the following:

- For inpatient claims, the increase does not apply to the capital per-diem, medical education per-diem (if applicable). This reimbursement is effective for inpatient hospital services with discharge dates on or after July 1, 2021, through June 30, 2023.
- For outpatient claims, the increase does not apply to clinical laboratory codes, details billed with revenue code 274, or details billed with revenue code 636. This reimbursement is effective for outpatient hospital services with "from" dates of service on or after July 1, 2021, through June 30, 2023.

MCEs are to follow Fee-for-Service (FFS) with determining what locations and services receive the increased reimbursement rate. In FFS, the NPI and LPI (plus service location identifier letter, if listed) that match the list of eligible out-of-state children's hospitals will get the increased reimbursement rate.

- If an off campus or on campus location is billing under a different NPI/LPI combination, those services would not qualify for the increased reimbursement rate.
- If an on or off campus location does bill under the NPI/LPI listed, then they would get the increased reimbursement rate.

For eligible out-of-state children's hospitals that already have a higher diagnosis related group (DRG) base rate, the MCE shall take the increased base rate from Myers and Stauffer and then multiply by 1.3. As an example: The normal DRG base rate is $100. The children's base rate for an eligible children's hospital like is $120. For dates of service on/after July 1, 2021, the MCE will take the base rate of $120 and multiply that by 1.3.

Section 6: 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 Hoosier Healthwise 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 quality 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" means 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 Hoosier Healthwise members. The MCE may establish different provider and member incentives for its Hoosier Healthwise populations.

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:

- Complete quality 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.

6.1 Quality Management and Improvement Program

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, Diagnostic, 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 Hoosier Healthwise populations. 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
  - Blood lead testing
  - Dental
  - Emergency room utilization
  - Access to care
  - Special needs care coordination and utilization
  - Asthma
  - Obesity, especially childhood 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 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 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 room services; keeping appointments and scheduling appointments for routine and preventive services, such as prenatal care; disease screenings; compliance with behavioral health drug therapy; compliance with diabetes treatment, and well-child visits.
- Participate in any state-sponsored prenatal care coordination programs.
- Contract for an NCQA-accredited HEDIS audit and report 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 that is based upon the NCQA methodology for sampling and report results to the state annually.
- Include a provider relations project annually.
- Participate in other quality improvement activities, including External Quality Reviews, to be determined by the state.
- Eligibility redetermination for Hoosier Healthwise members occurs at intervals determined by the Division of Family Resources (DFR). Intervals vary for Hoosier Healthwise members.
- Managed care entities (MCEs) may assist members in the redetermination process but must offer the same level of assistance to all members equally. Members are ultimately responsible for completing redetermination materials, signing the redetermination form, and submitting these materials to the DFR by the required deadline.

6.1.1 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 Hoosier Healthwise 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 Hoosier Healthwise populations 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* contain more information about the annual *Quality Management and Improvement Program Description, Work Plan and Evaluation.*

6.1.2 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.

6.2 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.

6.2.1 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, the IHCP must comply).
2. Indiana Code – All review criteria must comply with Medicaid-specific provisions of the Indiana Code.
3. State Plan – Review criteria are subject to the terms of the state plan (which is the IHCP agreement with the Centers for Medicare & Medicaid Services [CMS] outlining the coverage and reimbursement of IHCP 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 IHCP provider reference modules, bulletins and banner pages. MCEs must follow IHCP Policy (fee-for-service criteria) exactly for the following items:

    - ABA Therapy: IHCP Bulletins BT201867, BT201953 and Behavioral Health Services provider reference module
    - Drug Testing: IHCP Bulletins BT201846, BT202183 and Laboratory Services provider reference module
    - EndoPredict-Breast Cancer: IHCP Bulletin BT202010 and Genetic Testing provider reference module
    - Hysterectomies: IHCP Bulletin BT201976 and Obstetrical and Gynecological Services provider reference model
    - ReliZorb (in-line cartridge containing digestive enzymes for enteral feeding): IHCP Banner Page BR202050 and Durable and Home Medical Equipment and Supplies provider reference module
    - Speech-Generating Devices: IHCP Bulletin BT202012 and Durable and Home Medical Equipment and Supplies provider reference module
    - Spinal Stenosis: IHCP Bulletin BT2020111 and Surgical Services provider reference module
    - Transplants: IHCP Bulletin BT202019 and Surgical Services provider reference module
    - Bariatric Procedures: IHCP Bulletin BT202240 and Surgical Services provider reference module
    - Oxygen Usage: IHCP Bulletin BT202242 and Durable and Home Medical Equipment and Supplies provider reference module

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).
    - 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.

- **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

The OMPP reserves the right to add additional or remove the Fee-for-Service Criteria and will provide the MCEs with appropriate notice.

<u>Established Utilization Management policy that is current and shall remain in policy:</u>

- 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.

6.2.2 The Right Choices Program

The Right Choices Program (RCP) is the lock-in program developed by the Indiana Health Coverage Programs (IHCP) in accordance with *Code of Federal Regulations 42 CFR Sections 455* and *456* and *Indiana Administrative Code 405 IAC 1-1-2(c)*. The purpose of RCP is to identify members who use covered services more extensively than their peers. 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. Program policies, set forth by the state for RCP, are 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 Administration Manual*, including, but not limited to, the following:

- Evaluate 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 and pharmacies.
- Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management, and care coordination with the goal of modifying member behavior.
- Provide appropriate customer service to providers and members.
- Evaluate and monitor the member's compliance with 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 ad-hoc 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.

6.2.3 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©(4)*, 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 6.3 of the *Hoosier Healthwise Contract 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
- 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, including information on exhausting the MCE's one level of appeal
- 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 five (5) 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 5-3-14*, 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 for service. 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 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).

6.2.4 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)

6.2.5 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.

6.2.6 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 line 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 one hour to all emergency room 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

Section 7: Program Integrity

7.1 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 of this manual.
- 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 manager and surveillance and utilization review (SUR). In the event of member fraud, please contact with a copy to FSSA Bureau of Investigation.

7.1.1 Additional Program Integrity Requirements

The Indiana Office of the Attorney General, Medicaid Fraud Control Unit is the state agency responsible for the investigation of provider fraud in the Indiana Medicaid program.

The OMPP Program Integrity Unit (OMPP PI), is responsible for overseeing the integrity of all Medicaid payments issued by the state for services on behalf of Medicaid-eligible beneficiaries and referring cases of suspected fraud to the MFCU for investigation. The OMPP PI 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 non-contract, shall comply with all federal requirements (*42 CFR Part 455*) on disclosure reporting, including business transaction disclosure reporting (*42 CFR 455.105*) and the full ownership and control information (*42 CFR 455.104*) and shall further provide any additional information necessary for the FSSAS to perform exclusion status checks pursuant to 4*2 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 time frames 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.

7.2 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.
- 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).
- MCE is required to conduct and maintain at a minimum the following operations and capabilities. MCE shall conduct all operations and deploy all capabilities described below on a routine basis and as necessary for the effective reduction of Medicaid waste, fraud and abuse.
- The Special Investigation Unit within the 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.

MCE shall submit to FSSA for approval the criteria utilized for its review of its members and the referral of members to the Right Choices Program.

7.3 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).

7.3.1 Reporting Waste, Fraud and Abuse

- The MCE must immediately notify the OMPP PI Unit when it has identified a provider with a potential credible allegation of waste, fraud and abuse.
- 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 non-compliance remedies 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.

7.3.2 Investigation of Waste, Fraud, and Abuse

The MCE must promptly perform a preliminary investigation of all incidents of suspected 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 must 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 must 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.

7.3.3 Credible Allegation of Fraud

The MCE must comply with *42 C.F.R. § 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.

7.3.4 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 also specify individual provider recoupment, repayment schedules, and actions taken for each audit or investigation. The quarterly progress report must identify recoupment totals for the reporting period. **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 also identify projected upcoming activity, including the top 20 providers on MCE's list for audit, and the types of audits envisioned.
- The OMPP PI Unit shall review and approve, approve with modifications, or reject the *Audit Report* and specify the grounds for rejection.
- Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the OMPP PI Unit) must also be submitted in the *Audit Report.*
- In accordance with 42 CFR 438.608(d)(3), the MCE must report annually to the state on the recoveries of overpayments.

7.3.5 HIPAA or Other Security Breach

The MCE shall notify the OMPP within one business day upon discovery of a HIPAA or other security breach.

7.4 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.

7.5 Auditing Program Integrity Operations

The OMPP PI Unit may conduct audits of MCE's SI Unit activities to determine the effectiveness of 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. The failure to adhere to operational improvement measures may result in the state's imposing liquidated damages up to the amount of overpayments recovered from MCE's providers by OMPP PI Unit audits for the preceding calendar year, or imposing other non-compliance remedies including liquidated damages as outlined in the contract.

Managed care entities (MCEs) contracting with the Family and Social Services Administration (FSSA) to administer the Hoosier Healthwise 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' Hoosier Healthwise programs.

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 with this area of critical importance to Hoosier Healthwise program members. MCEs are required to report EPSDT compliance through submission of encounter data, as described in the Management Information Systems section.

Section 8: Information Systems

The managed care entity (MCE) must have a management information system (MIS) sufficient to support the Hoosier Healthwise 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 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 pharmacy data received from the state fiscal agent for utilization analysis and care management activities. The state must provide the MCE with pharmacy claims data on the MCE's Hoosier Healthwise members on a weekly basis through the state fiscal agent. The state must also provide access to real-time pharmacy profiles of Hoosier Healthwise members via a web portal.

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 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 are 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 claim 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.

8.1 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 MCE or the OMPP PI Unit as engaging in inappropriate or abusive billing or service provision practices.

If a fraud referral from 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 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 recove4red 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 State 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 specific providers 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.

8.2 Disaster Recovery Plan

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 claim 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 claim 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*MMIS (or the Indiana *Core*MMIS, as applicable) if the claim 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

8.3 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, 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 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.

> ***Note:*** *Optum Rx is responsible for processing all pharmacy claims and data extracts for the Hoosier Healthwise program. Furthermore, legend and nonlegend drugs are covered by Optum Rx under the pharmacy benefit.*

8.3.1 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 as specified in the scope of work.

8.3.2 Precycle Edits

For each weekly encounter claim batch submission, the MCE must achieve no less than 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 as specified in the scope of work.

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 Hoosier Healthwise 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.

8.3.3 Encounter Claims Quality

The MCE shall have written policies and procedures to address its submission of encounter claims to the state. These policies shall address the submission of encounter data from any subcapitated providers or subcontractors. At least annually, or on a schedule determined at the discretion of the state, the MCE shall submit an encounter claims work plan that addresses the MCE's strategy for monitoring and improving encounter claims submission.

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. Void/replacement claims for Hoosier Healthwise members must be submitted within two years from the date of service. 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.

8.4 Encounter Data Edits and Audits

Hoosier Healthwise encounter data is subjected to appropriate system edits to ensure that data is valid. These edits fall into the following two broad categories:

- Electronic claim capture (ECC) pre-cycle edits
- Claim resolution edits and audits (also referred to as back-end edits)

Pre-cycle editing establishes the presence and validity of critical data elements before the claim's acceptance into *Core*MMIS. For example, to pass the pre-cycle edit, the *Member ID* field must contain a valid combination of numeric characters recognized by *Core*MMIS. The pre-cycle editing process does not attempt to link the number to a specific member's eligibility or other information. The ECC pre-cycle edits for encounter data are identical to those in FFS electronic claim submission (ECS) claims, except for the addition of two edits created for encounter data: MCE ID MISSING and MCE ID INVALID. The pre-cycle edits are described in the Companion Guide: Electronic Data Interchange Reports and Acknowledgements.

The EDI translator used by the fiscal agent is EDIFECS. Information about this initiative is available at the Common Compliance Errors Detected by the IHCP Translator page at in.gov/medicaid/partners and is updated regularly.

Claim resolution editing and auditing validates information specific to a particular enrollee's IHCP program eligibility, subprogram affiliation, and claim history. These edits and audits are designed to support benefit limits and conditions of payment in state and federal requirements and are described fully in *the fiscal agent Claim Edits and Audits data file*. For example, a claim with a Member ID accepted in *Core*MMIS during pre-cycle editing may be denied during claim resolution editing if the member was ineligible for benefits on the date of service, or if the member's name or Member ID on the claim did not match the name or Member ID on file in *Core*MMIS.

The state fiscal agent provides quarterly claim edit and audit information via File Exchange that includes the historical and current editing documentation as defined by the state and coded in *Core*MMIS.

In IHCP's FFS claim processing environment, generating system edits and audits causes claims to be suspended for review, pended to request additional information, or denied. In the encounter data environment, claims are subjected to the same edit and audit criteria for data collection, utilization, and program comparison. Because encounter data has been fully adjudicated by the MCE, it adjudicates in *Core*MMIS as paid or denied.

The FFS edits and audits related to validity of data, member eligibility, provider enrollment, or duplicate claim submissions are also active for encounter data claims. FFS audits limiting duration or frequency of specific services, restricting place of service, or requiring prior authorization are inactive, or post and pay for encounter data. Claims that are potential (but not exact) duplicates adjudicate as paid, because the MCE has determined the validity of the paid claim before its submission as encounter data.

The disposition of each edit and audit applicable to encounter data is recommended by the fiscal agent managed care director or designee and approved by the state managed care director or designee. MCEs can request a review of the disposition of a specific edit or audit by submitting a request to the state's fiscal agent managed care director.

Generation of the FFS edits and audits in an encounter data processing environment causes claims to adjudicate with a paid or denied status in *Core*MMIS*,* even though payments are not actually issued. Encounter data is not suspended or pended for review because it reports claims payments adjudicated by MCEs to their contracted and non-contracted providers.

8.4.1 Encounter Data Output Documents

*Core*MMIS acknowledges each encounter submitted by the MCE. This acknowledgment includes the *Encounter Submission Summary Report*, an electronic Remittance Advice (RA) and the *835 Remittance Advice Transaction.*

8.4.1.1 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 p.m. 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.

8.4.1.2 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 Hoosier Healthwise encounter claims errors.

8.4.2 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 *Encounter 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.

MCEs may bring questions about any aspects of encounter data submission and adjudication to the monthly MCE Technical Meeting.

8.4.3 Encounter Data Adjustments

The void and replacement process through *837 Professional and Encounter Claim Transaction* allows MCEs the ability to adjust or reverse an adjudicated Hoosier Healthwise claim with a paid status. Additional claim filing elements, unique to Hoosier Healthwise encounter data adjustments, are described as follows:

- The MCE ID, provider ID, and state region must appear on the replacement exactly as they appear on the claim being replaced. If the NPI is used on the claim, the taxonomy and service location ZIP Code+4 on the replacement must be identical to those on the claim being replaced.
- The MCE ID, provider ID, state region, and member information on a void must be identical to the same information on the claim being voided. If the NPI is used on the claim, the taxonomy and service location ZIP Code +4 on the void and on the claim being voided must be identical.
- The type of claim on the void or replacement must be the same type on the claim being voided or replaced.
- The void or replacement cannot be older than two years from the dates of service on the claim being voided or replaced.
- The void or replacement request must be completed against the most recent occurrence of the bill.
- The void or replacement request must be for an IHCP claim that is found in the database.
- A void cannot be processed against a claim that denied in *Core*MMIS.
- A replacement request cannot be performed against a claim that denied because of a previous void request.

Additional instructions for void and replacement, as well as information about file formats, are in the *837P Health Care Claim: Professional Transaction* and *837I Health Care Claim: Institutional Transaction*, companion guides.

8.5 Member Enrollment and Capitation Data Exchange

The MCE is required to accept enrollment data in the HIPAA-compliant 834 electronic format. See the *834MCE 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 companion guides are available on the [*Electronic Data Interchange (EDI) Solutions*]() page at in.gov/medicaid/providers. 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 generate twice a month for Hoosier Healthwise, on the 1st and 15th. Audit files for 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.

Capitation cycles run monthly for Hoosier Healthwise. The Hoosier Healthwise 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. Presumptive eligibility for pregnant women is processed as part of the Hoosier Healthwise cycle. Funds are then transferred via electronic funds transfer (EFT) to the MCE the middle of the following week after 820s are produced.

The Hoosier Healthwise 820 also encompasses capitation adjustments.

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 Hoosier Healthwise capitation rate adjustments result in a greater dollar amount of recoupments than routine per-member, per-month payments, outgoing payments won't generate until all the recoupments have been satisfied.

Capitation is always driven by MCE and PMP assignments. MCEs receive full- or half-month capitation for Hoosier Healthwise and PE members, depending on the number of days a member is assigned to the 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.

For PEPW members, the two programs, PE and Hoosier Healthwise, must be considered separately. The MCE receives two capitation payments for all bisect members: one for PE and one for Hoosier Healthwise. Capitation is not driven by a program change; it is driven by the PMP assignment.

The MCE is responsible for verifying member eligibility and receipt of capitation for each eligible member. The MCE must reconcile its eligibility and payment records monthly for Hoosier Healthwise. If the MCE discovers a discrepancy in eligibility or capitation, 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 to the state within 45 calendar days of discovering the discrepancy. If the MCE receives enrollment information or capitation, the MCE is financially responsible for the member.

Enrollment may change at any time. For example, a Hoosier Healthwise 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 IEDSS. Deleted records include an INS03 segment of 024.

8.6 Claim 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.

8.6.1 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 claim 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 claim 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 claim 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 90 days. 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 non-contracted providers outlined in 405 IAC 1-1.6-1.

8.6.2 Compliance With State and Federal Claim 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.

8.6.3 Claim 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.

8.5.4 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 MCE 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.

8.6.4 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 managed care director. The notification includes the capitation categories, time period, newly calculated rate, and the affected MCE/region. Adjustments can apply to Hoosier Healthwise capitation rates.

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

For example, a Hoosier Healthwise Package C member may become retroactively eligible for Package A. The capitation reconciliation process automatically detects the eligibility change and recoups the outdated rates, in addition to paying the updated rates.

8.6.5 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.

8.7 Rate Information

MCEs may negotiate their own rates with network providers that do not fall under a directed payment (such as HAF and PFAC). MCEs must pay 98% of the IHCP fee schedule for out of network Hoosier Healthwise providers.

8.7.1 IHCP Fee Schedules

The Indiana Health Coverage Programs (IHCP) publishes two fee schedules on the *Fee Schedule* page at in.gov/medicaid/providers. The IHCP Fee schedules reimbursement information for 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 Professional Fee Schedule reflects the most current allowed rate for all procedure codes pertinent to CMS-1500, 837 professional, and dental billers. The Professional Fee Schedule contains the following information:

- Procedure Code/Description
- Modifiers (1-4)
- Service Category/Description
- Rate Type
- Pricing Method
- Pricing Effective Date/End Date
- PA Required
- Attachment Required
- Min-Max Units
- Fee schedule amount
- Base Units
- Age Min-Max
- CMS Add Date/Termination Date

The IHCP Outpatient Fee Schedule contains outpatient facility payment information for applicable procedure codes and revenue codes, including ambulatory surgical center (ASC) rates that are used for paying outpatient surgery claims.

The IHCP Professional Fee Schedule information is updated each Tuesday at 4 p.m. with information current as of the previous Sunday. IHCP Outpatient Fee Schedule is updated and published monthly.

8.7.2 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.
- Max 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.
- Max 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.

8.7.3 Claim Elements Unique to Hoosier Healthwise Encounter Data

Hoosier Healthwise encounter data mirrors fee-for-service (FFS) claims, ensuring the continuity of Medicaid data collected. Additional claim filing elements, unique to Hoosier Healthwise encounter data processing and submission, are described as follows:

The MCE Identification Number and Region Identifier is assigned to an MCE when it enrolls in Hoosier Healthwise. This ten-digit number's tenth digit denotes the geographic region of the state where the MCE is contracted to provide services. The MCE ID and region identifier are required on all encounter-data submissions.

Value codes and value-code amounts are required on the electronic 837 institutional claim submission format to designate the MCE's reimbursement and actual amount paid on the claim. Omission or

incorrect data in the value-code fields causes the claim to adjudicate with a denied status for one of the following reasons:

- Value code missing
- Value-code amount missing
- Value-code amount invalid

8.7.3.1 Coordination of Benefits 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.

Additional claim elements that need to be included for Hoosier Healthwise encounter data can be found in the, *837P Health Care Claim: Professional Transaction* and *837I: Health Care Claim: Institutional Transaction* companion guides.

8.7.3.2 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 9999 limitation, the Hoosier Healthwise 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.

8.7.3.3 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.

8.7.3.4 Capitated Provider Encounters

The MCEs must submit CMS-1500 claims that report services rendered under a Hoosier Healthwise provider-capitated arrangement by sending the LOOP 2320 Segment CAS with ARC code 24 and $0.00 as the billed amount.

8.7.3.5 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 Hoosier Healthwise 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.

Hoosier Healthwise fully denied professional and institutional encounter claims are indicated in the 837 transaction in one of the following manners:

- Loop 2300 HCP01 = 00 and HCP02 = 0
- 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.

MCEs have up to 15 months from the date of service to submit denied Hoosier Healthwise 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.

8.7.3.6 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.

8.7.3.7 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 utilized 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.

8.8 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. MCEs must not deny claims for TPL for newborns less than 30 days old.

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.

8.8.1 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.

8.8.2 Hoosier Healthwise Package A

If the Hoosier Healthwise 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.

8.8.3 Hoosier Healthwise Package C

An individual is not eligible for Hoosier Healthwise Package C if they have other health insurance coverage. If the MCE discovers that a Hoosier Healthwise Package C member has other health insurance coverage, it is not required to coordinate benefits but must report the member's coverage to the state. The MCE must assist the state in its efforts to terminate the member from Hoosier Healthwise Package C because of the existence of other health insurance.

The types of other insurance coverage the MCE must coordinate with include insurance such as worker's compensation insurance and automobile insurance.

8.8.4 Third-Party Liability Data Sources

The state fiscal agent provides each MCE with a monthly list of known TPL resources for its enrolled Hoosier Healthwise 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 restricted page under File Formats.

Medicare information is also provided to the MCEs for Hoosier Healthwise members who have overlapping Medicare. The Medicare extract file layout is available on the MCE restricted page under *File Formats*. 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:

- Member's caseworker
- HMS, the fiscal agent's subcontractor
- Other MCEs Portal
- Providers

The fiscal agent verifies for accuracy all TPL information received (except when the information comes from the caseworker).

TPL information can be submitted via the Portal > Eligibility inquiry by selecting *TPL Form*.

8.8.5 MCE TPL 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.

8.8.6 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.

8.8.7 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 Hoosier Healthwise Package A and P members.

For Hoosier Healthwise Package C members, the MCE may retain all TPL collections from any insurer or responsible party other than health insurers (such as automobile insurers, workers compensation, and so forth). In an effort to incentivize MCEs to investigate whether members have obtained health insurance that would exclude them from Hoosier Healthwise Package C eligibility, the MCE may keep 30% of the recovery collected from other health insurers but must transfer the remaining 70% to the state within 30 calendar days of collection.

8.9 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 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 9 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 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, 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 HIP folder 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 5 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 policy analyst with a 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 policy analyst 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 the Scope of Work.

As required to meet the deliverables in the Scope of Work or as requested by the state, a managed care entity (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.

9.1 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 Hoosier Healthwise 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.

9.1.1 Provider Incentive Programs

MCEs 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 Medicaid fee-for-service fee schedule.

Section 1876(i)(8) of the *Social Security Act* and federal regulations *42 CFR 428.10(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)*.

9.1.2 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 quitting smoking or losing weight
- Completing a health needs screen

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. For Hoosier Healthwise, allowable preventive care services include well baby and well child visits, prenatal and postnatal care, and clinical services described in the current *U.S. Preventive Service Task Force's Guide to Clinical Preventive Services.* 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 room 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.

9.1.3 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 the Notification of Pregnancy section of this manual.

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 Process section. This reimbursement amount must be passed on to the provider that completed the NOP form. 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.

Appendix A: Hoosier Healthwise Capitation Payment Transaction Codes

Monthly, the managed care entities (MCEs) access Hoosier Healthwise capitation data using the 820 MCE Capitation Payment Transaction. The following tables provide the codes applicable to the Hoosier Healthwise 820 transaction file.

The following tables list applicable MCE capitation rate cells, region codes, and reason codes related to capitation. This information is derived from the Managed Care subsystem in *Core*MMIS.

Table 2 – Hoosier Healthwise MCE Capitation Rate Cells

Description	Capitation Categories
Package A Preschool Ages 1 to 5	A1
Package A/B/P Child Ages 6 to 12	A6
Package A MA-U Female	UF
Package A MA-U Males	UM
Package A MA-U Preschool Ages 1 to 5	U1
Package A MA-U Child Ages 6 to 12	U6
Package A MA-U Teen Ages 13 to 20	UT
Package A MA-U Newborn	UN
Package A MA-U Delivery Payment	UD
Package C Preschool Ages 1 to 5	C1
Package C Child Ages 6 to 12	C6
Package A/P Adult Female	AF
Package A Adult Male	AM
Package A Newborn 0 to 12 Months	NB
Package A/P Teen	TN
Package A/B Delivery Payment	DP
Package C Teens Age 13 to 18	CT
Package C – Newborn 0 to 12 Months	CN
Package C – Delivery Payment	CD
Package A/B – NOP Payment	NP
Package A MA-U – NOP Payment	UP
Package C – NOP Payment	CP
Pkg. A Transitional Adult Females	TF
Pkg. A Transitional Adult Males	TM
Delivery case rate for HHW and Package C	DH
PKG A Pregnancy	PH

Description	Capitation Categories
Nursing Home and Waiver PD	TW
Other Institutional, Waiver ID, and Full Duals	TI
Foster and Other	TO
Low Income Family	TL

Table 3 – Hoosier Healthwise MCE Payment Reason Codes

Description	Capitation Reason Codes
Payment – Half Month Normal	HN
Payment – Delivery Increase	PD
Payment – Normal	PN
Payment – Retro	PR
Payment – Adjustment Auto Recon	PV
Recoupment – Death	RD
Recoupment – Delivery Systematic	RS
Recoupment – Adjustment Auto Recon	RV
Recoupment – Normal Payment Notice of Pregnancy	NP
Recoupment – Notification of Pregnancy	RN

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 8 – 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: Interface Schedule

This appendix provides the schedule of the various extracts that are provided to the managed care entities (MCEs) and exceptions to the schedule.

Figure 9 – Interface Schedule – Input to Fiscal Agent

INPUTS

File	I/O	Entity	Frequency	When expected	Holiday Exceptions/Notes
PMP Assignments					
HIP/HHW PMP Assignments	Input	MCE	D	Mon-Fri 6pm	Files received past cut-off will not be processed, Only one file per day M-F should be submitted, The job will success without receiving a file. The jobs will run if files are received, regardless of holidays.
Eligibility					
HIP Pending (GDE462FA)	Input	ICES	D	Mon-Fri	HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.
HIP Conditional (GDE462FB)	Input	ICES	D	Mon-Fri	HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.
Recipient Eligibility (GDE429FA)	Input	ICES	D	Mon-Fri	HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.
Companion Case ID (GDEW084FA)	Input	ICES	D	Mon-Fri	HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.
HIP Eligibility					
HIP Pay/No Pay Data	Input	HIP MCE	D	Mon-Fri 5pm	Files received past cut-off will not be processed. Only one file per day M-F should be submitted. The job will success without receiving a file. HPE does not process files on days ICES doesn't run (OMPP holidays).
HIP Pay/No Pay Data	Input	HIP MCE	M	Each month by the 10th at 5pm	Files received past the adverse action cut-off date will not be processed.
HIP Pay/No Pay Data ICES Response (GDE422FB)	Input	ICES	D/M	In response to D/M files passed by the MCEs via HPE	ICES files do not run on OMPP holidays. The combined file response from HPE is therefore impacted by OMPP holidays.
Interface with Enrollment Broker					
Member Assignment File	Input	Maximus	D	Mon-Sat 6pm	Files received past cut-off will not be processed. Only one file per day M-S should be submitted.

Figure 10 – Interface Schedule – Output from Fiscal Agent

OUTPUTS

File	I/O	Receiving Entity	Frequency	When generated	Holiday Exceptions/Notes
Provider Enrollment					
NPI Reference	Output	MCE	D	Mon-Fri	Not affected by holidays
OPR Provider File	Output	MCE	W	Friday	Not affected by holidays
Provider Profile	Output	MCE	M	1st day of each month	Not affected by holidays
PMP Assignments					
HIP/HHW PMP Response File	Output	MCE	D	Mon-Fri	Corresponds to the MCE submitting a file
HIP/HHW PMP History	Output	MCE	D	Sun-Fri evening	Can potentially produce files 6 days per week, regardless of holidays. Does not run on Sat.
HIP Eligibility					
HIP 834 Conditional	Output	MCE	D	Tues-Sat early morning	ICES does not run on OMPP holidays, however AIM may still generate records. If no updates, an 834 won't generate and the MCE will be notified via DSIBPROD email.
HIP 834 Fully Eligible	Output	MCE	D	Tues-Sat early morning	ICES does not run on OMPP holidays, however AIM may still generate records. If no updates, an 834 won't generate and the MCE will be notified via DSIBPROD email.
HIP 834 Monthly Audit	Output	MCE	M	1st day of each month	Not affected by holidays
HIP Pay/No Pay Response File	Output	HIP MCE	D/W	Corresponds to the MCE submitting a file	Response files generate the same night the files are processed (approx 11:30pm)
HIP Medicare Extract	Output	HIP MCE	M	20th of each month	Not affected by holidays
HIP Member TPL Information	Output	HIP MCE	M	20th of each month	Not affected by holidays
HHW Eligibility					
HHW 834 Fully Eligible	Output	MCE	D	Tues-Sat early morning	The jobs that create the 834s start running Mon-Fri evenings. ICES does not run on OMPP holidays, however AIM may still generate records regardless of holidays.
HHW 834 Audit	Output	MCE	2xM	1st and 15th of each month	Not affected by holidays. Job begins on the 1st and 15th; may be the 2nd and 16th when posted to FE.
HHW Medicare Extract	Output	HHW MCE	M	20th of each month	Not affected by holidays
HHW Member TPL Information	Output	HHW MCE	M	20th of each month	Not affected by holidays
Presumptive Eligibility					
Approved QPs by file transfer protocol (FTP)	Output	HHW MCE	D	Mon-Fri	Not affected by holidays
Interface with Enrollment Broker					
Recipient Assignment Transaction (HASSIGN)	Output	EB	D	Mon-Sat	Does not run on OMPP holidays

Appendix D: Preferred Medical Provider Assignments From the MCEs

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 Hoosier Healthwise 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 or eight numeric characters followed by one alpha character
- PMP's Medicaid location, individual or group – Required, one alpha character
- Member's health program – R (RBMC)
- 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 – Required for RBMC
- 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 the Hoosier Healthwise 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 – R (RBMC)
- PMP's Medicaid group Provider ID – If present, nine numeric characters
- MCE ID – Required, nine numeric characters
- PMP's region code – Required for RBMC
- 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.

Hoosier Care Connect member process is not affected by these Hoosier Healthwise 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 > 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 Use

Table 4 – 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.

TXN Type	Usage	Date Effective	Date End	Notes
				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 don't have a PMP replacement yet	Effective date of the PMP assignment that's 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 that's being deleted	End date of the PMP assignment that's being deleted	An assignment cannot be deleted if it's already taken effect.
T	Not for use by MCEs; reserved for the enrollment broker	N/A	N/A	N/A

Table 5 – PMP Assignment and Eligibility Scenarios

ID	Scenario	Effect on Submissions	Effect on Current Assignments
1	Hoosier Healthwise member maintains their eligibility.	No effect. MCEs are able to make changes.	No effect; the assignment remains on file.
2	Hoosier Healthwise member loses their eligibility; member is not reopened.	MCEs are not able to submit PMP assignments beyond the IHCP eligibility end-date.	The PMP assignment is systematically end-dated in conjunction with the IHCP eligibility end-date. 834 term record is sent to the MCE.
3	Hoosier Healthwise member loses their eligibility; member is reopened without a break in coverage.	The original PMP assignment reopens; therefore, the MCE does not have to resend the PMP assignment.	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's PMP assignment also reopens as if it was never closed, as long as the stop reason on file is a 99 (open) or 81 (eligibility end). An 834 change record generates, indicating a change in eligibility dates.
4	Hoosier Healthwise 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 prospectively back to the MCE with a PMP placeholder assignment. Effective date of the placeholder is either the 1st or the 15th of the month, depending on what date ICES reopens the eligibility.

Appendix E: Auto-Assignment Reason Codes

Applicants have the option to preselect their managed care entity (MCE) when applying for the Hoosier Healthwise program. This information is transmitted from IEDSS to *Core*MMIS after the member is determined fully eligible. If there is no MCE preselection, the member record is held for 14 days so the enrollment broker can outreach to the member and assist with the MCE selection. If after 14 days, the member is not assigned to an MCE, *Core*MMIS auto-assignment logic assigns the member to a Hoosier Healthwise based on their eligibility.

- MCE Assignment
- Post-MCE Assignment
- Post-PMP Assignment
- PMP Disenrollment

The following are exceptions to the 14-day wait period and members are assigned immediately:

- Members previously enrolled in the Right Choices Program (RCP)
- Hoosier Healthwise members with less than a two-month gap and more than 90 days from annual open enrollment period.
- Hoosier Healthwise members whose psychiatric residential treatment facility (PRTF) level-of-care (LOC) has ended.

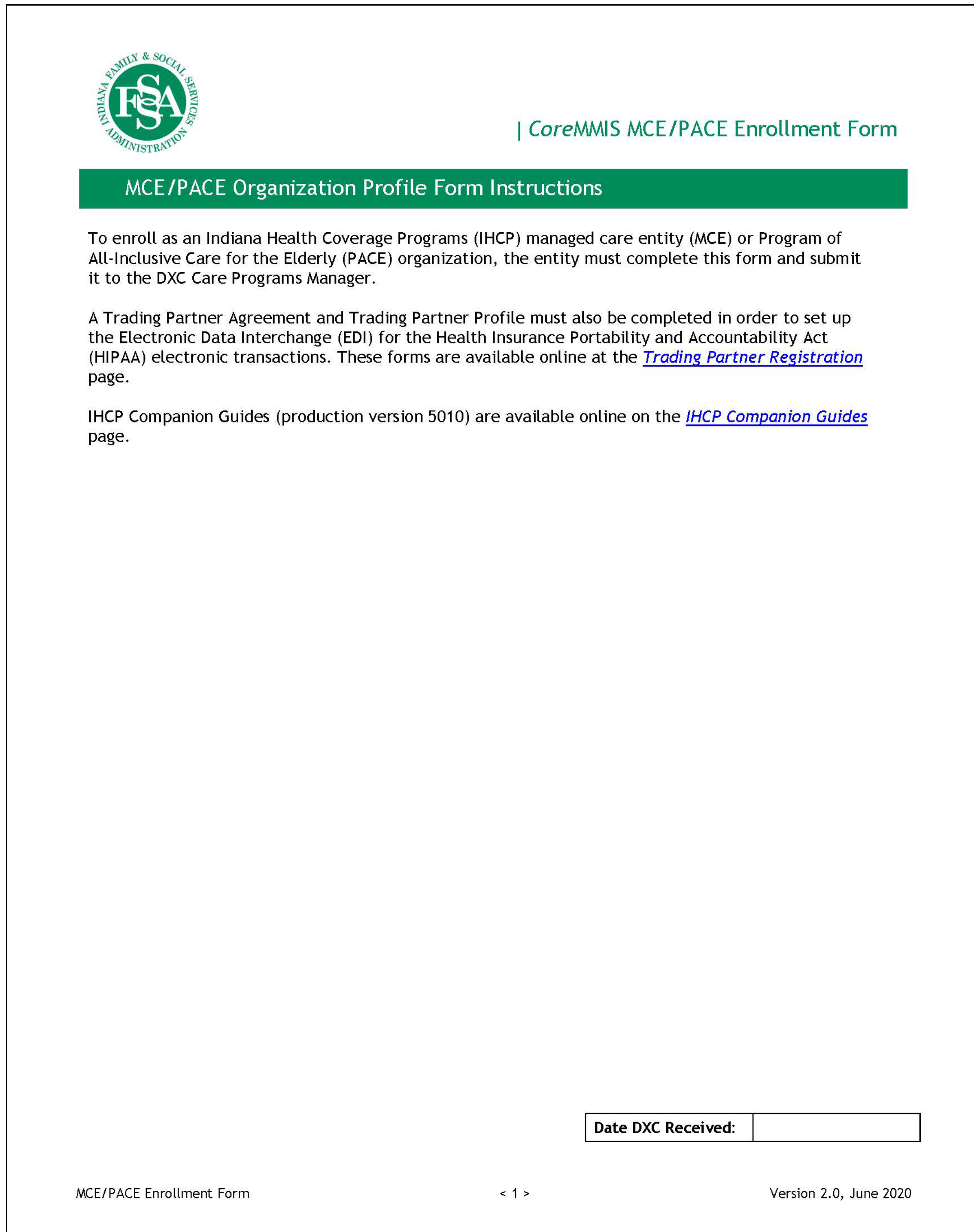
The following table provides the auto-assignment reason codes and descriptions used for the various care programs.

Table 6– Active Hoosier Healthwise/CS AA Codes

ID	Description
3A	Auto Assigned – Previous MCE
3C	Auto Assigned – Previous RCP
3D	Auto Assigned – Spouse (HIP)
3F	Auto Assigned – Newborn (Mom MCE)
3G	Auto Assigned – Member Choice
AA	Default Auto Assignment

Appendix F: MCE Enrollment Form

Figure 11 – 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.

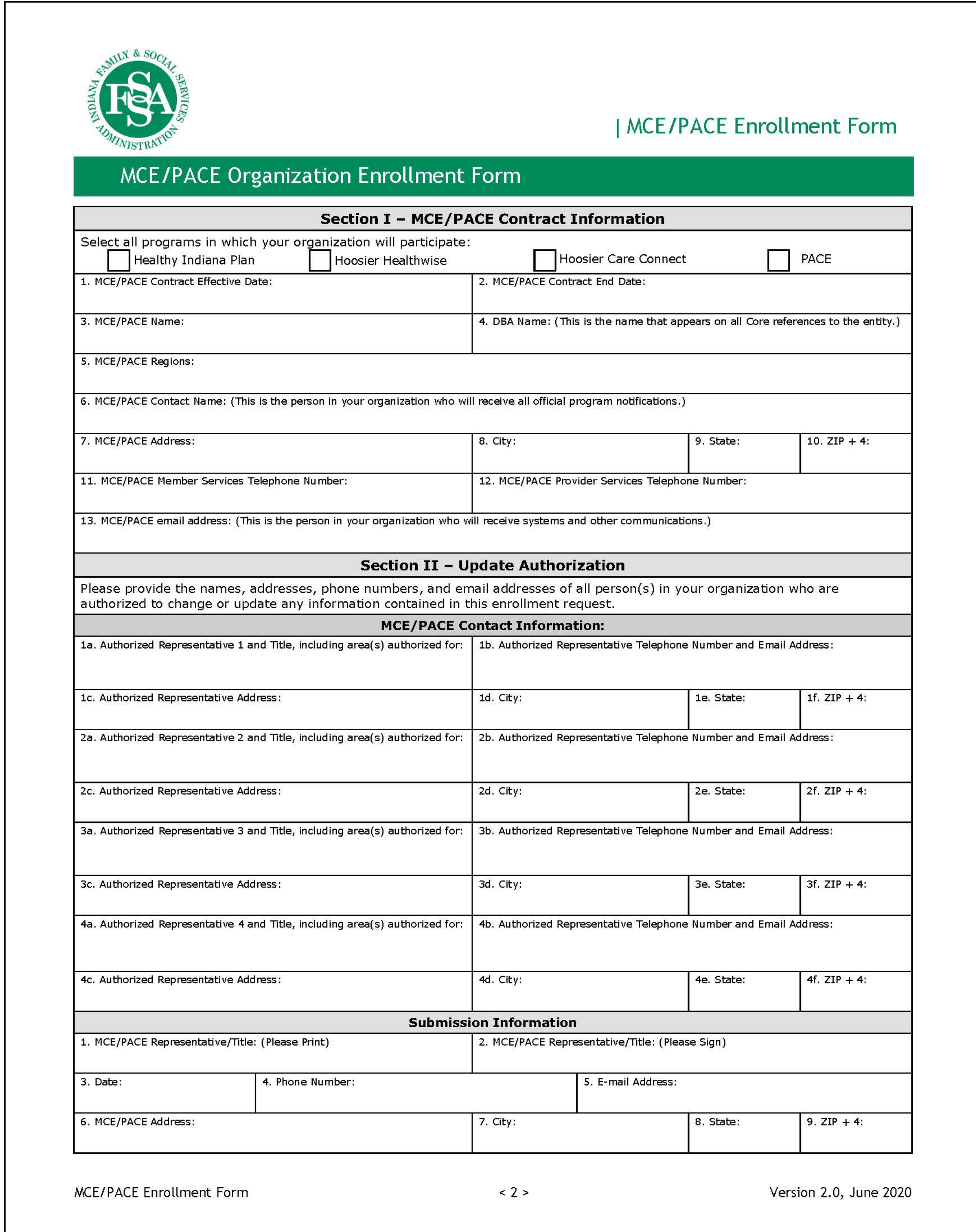
A Trading Partner Agreement and Trading Partner Profile must also be completed in order to set up the Electronic Data Interchange (EDI) for the Health Insurance Portability and Accountability Act (HIPAA) electronic transactions. These forms are available online at the *Trading Partner Registration* page.

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 11 – 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:

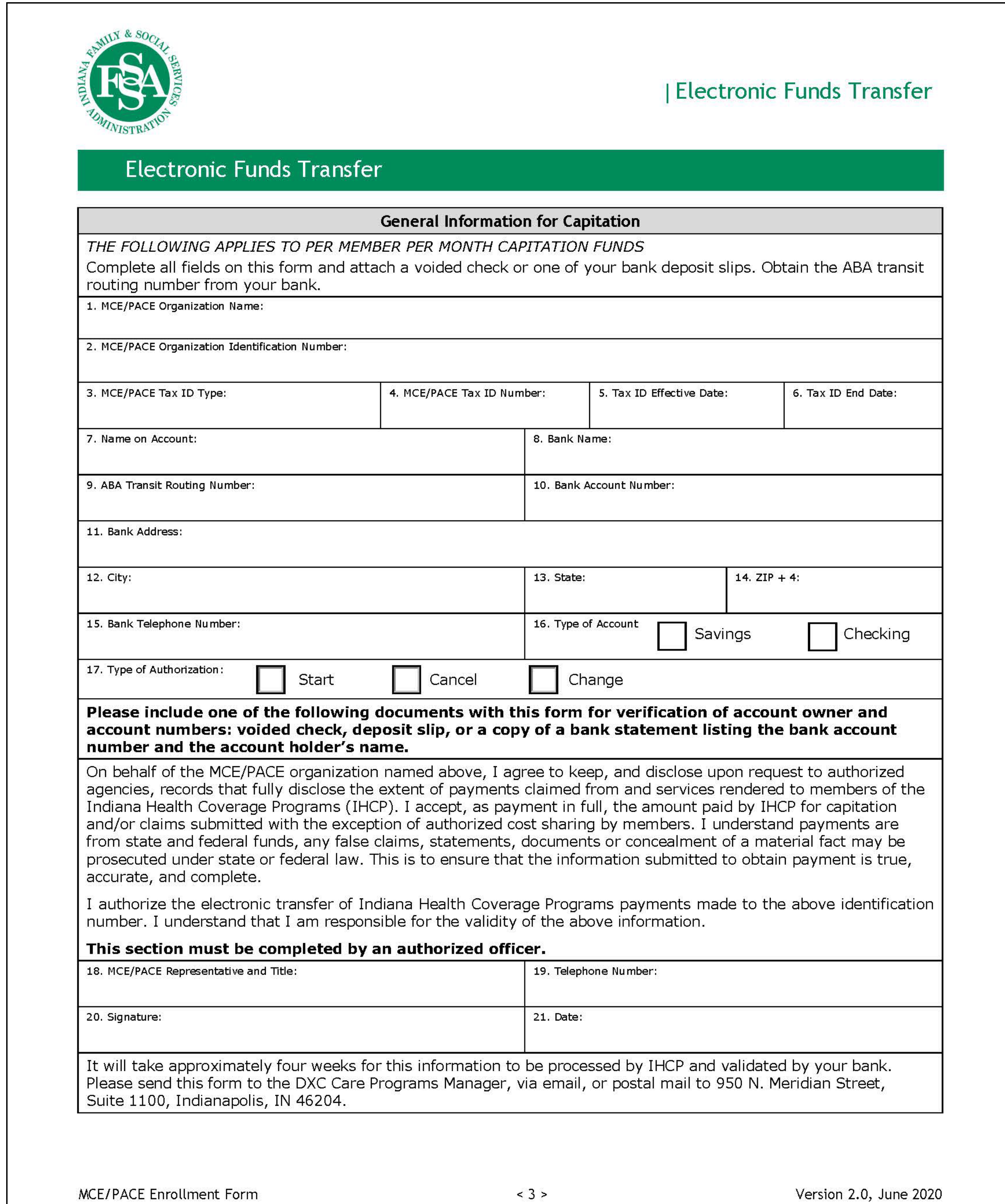
1a. Authorized Representative 1 and Title, including area(s) authorized for:	1b. Authorized Representative Telephone Number and Email Address:		
1c. Authorized Representative Address:	1d. City:	1e. State:	1f. ZIP + 4:
2a. Authorized Representative 2 and Title, including area(s) authorized for:	2b. Authorized 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 11 – 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

The following table depicts extracts and reports that are shared with or submitted the MCEs on a regular basis. These extracts and reports are generated by the state Fiscal Agent or the FSSA Enterprise Data Warehouse (EDW).

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

Report/Extract Title	Topic	Frequency	Definition of Report/ Extract	Source	File Location
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
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
835 Remittance Advice – Expenditure and Account Receivable transactions	Encounters	Daily	835 response to submitted encounters	MCE to Gainwell	File Exchange
Encounters - 277U Health Care Payer Unsolicited Claim Status Response	Encounters	Daily	837 Unsolicited Claim Status Response	MCE to Gainwell	File Exchange
Encounter Submission Summary Report (ESSR)	Encounters	Every Tuesday at 5pm	Consists of non-pharmacy encounter data received from CoreMMIS ~ flat file contains MMIS error code and edit information ~ serves as an acknowledgement file to MCEs that encounter is available for actuarial reporting	EDW	SFTP
Pharmacy Feed	Encounters	Every Saturday at 9am	Pharmacy encounter data submission to EDW	MCE to EDW	SFTP
Health Needs Screen	HNS	Monthly on 15th	Interface for HNS data from MCE to FSSA.	MCE to EDW	SFTP
Blood Led Report	Blood Led	Monthly on 15th	Each MCE receives the 5 attachments (Valid Tests, Line Graph, Pie Graph, Bar Graph and MCO Results) along with Medicaid enrollment information (2 files per MCE program HHW, HCC), 1 file for those BLS tests and 1 file for Medicaid enrollment: 1. those members that received a BLS test 2. a full list of enrollment in each MCE program for members under the age of 7 as of the processing month	EDW	SFTP
Quitline Report	Quitline	Monthly on 15th	MCE receives a report of all assigned members who contacted the Quitline during the month	EDW	SFTP
RCP Potential Report	RCP	Monthly on 15th	Access reports from EDW Cognos directly	EDW	Cognos Portal
Daily RCP MCE Interface	RCP	Daily	This is a pipe delimited extract of current RCP lock-in data that will be sent to each of the MCEs on a daily basis.	Gainwell	Gainwell File Exchange

Report/Extract Title	Topic	Frequency	Definition of Report/ Extract	Source	File Location
COGNOS_RCP_ANT	RCP	Monthly on 15th	This extract contains Right Choices Program summary for the Right Choices members MCE has assigned and potential Right Choices Program Recipients. Includes appeals, periodic review tracking, provider member file, transition report, and unassigned RCP provider member file.	EDW	SFTP
Cognos Accums Transfer Out	Accumulators	Monthly on 15th	The Summary and detail file contains accumulation of benefits the member has received when they transfer from another health plan to respective MCE.	EDW	SFTP
PMP List	PMPs	Monthly on 15th	This extract contains demographic information for PMP enrolled with respective MCE.	EDW	SFTP
MRO	MRO	Monthly on 15th	Medicaid Rehabilitation Optional Services (MROI) extract contains prior MRO services and Level of Needs information for members assigned to an MCE.	EDW	SFTP
COGNOS_MCE_FFStoMCTransfer_ANT	FFS to MCE Info	Monthly on 15th	This extract contains information regarding members that transfer from Indiana Fee-for-Service Medicaid to MCE. These replace the previous Claims extracts.	EDW	SFTP