AMENDMENT #1

CONTRACT #0000000000000000000051706

This is an Amendment to the Contract (the "Contract") entered into by and between the **Indiana Family and Social Services Administration (FSSA)** (the "State") and **COORDINATED CARE CORPORATION INDIANA d/b/a Managed Health Services, d/b/a MHS** (the "Contractor"), dated **April 1, 2021**.

In consideration of the mutual undertakings and covenants hereinafter set forth, the parties agree as follows:
The Contract for providing risk-based managed care services to Medicaid beneficiaries enrolled in the State of Indiana's Hoosier Care Connect program is hereby amended to update Exhibits 1, 2, 3, and 5.
Exhibit 1, which outlines the Scope of Work, is hereby superseded and replaced by **Exhibit 1.A.**, which is attached hereto and incorporated herein.

Exhibit 2, which outlines the Contract Compliance and Pay for Performance, is hereby superseded and replaced by **Exhibit 2.A.**, which is attached hereto and incorporated herein.

Exhibit 3, which outlines the Program Description and Covered Benefits, is hereby superseded and replaced by **Exhibit 3.A.**, which is attached hereto and incorporated herein.

Exhibit 5, which outlines the State's Capitation Rates, is hereby superseded and replaced by **Exhibit 5.A.**, which is attached hereto and incorporated herein.

Funding in the amount of **$74,273,711.10** is being removed from the total contract amount. Total remuneration for this contract shall not exceed **$2,066,457,465.76**.

All matters set forth in the original Contract and not affected by this Amendment shall remain in full force and effect.

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Non-Collusion and Acceptance

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

Agreement to Use Electronic Signatures

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

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

Coordinated Care Corporation Indiana

By: DocuSigned by: Kevin O'Toole 5BD776D5FE254B2...

Title: CEO

Date: 12/28/2021 | 13:55 CST

Indiana Family & Social Services Administration

By: DocuSigned by: Allison Taylor 3C2ABD79A80D498...

Title: Medicaid director

Date: 12/28/2021 | 15:01 EST

Electronically Approved by: Department of Administration By: (for) Rebecca Holw erda, Commissioner	
Electronically Approved by: State Budget Agency By: (for) Zachary Q. Jackson, Director	Electronically Approved as to Form and Legality by: Office of the Attorney General By: (for) Theodore E Rokita, Attorney General

EXHIBIT 1.A.
SCOPE OF WORK

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EXHIBIT 1.A.
SCOPE OF WORK

This Scope of Work is part of a Contract to provide risk-based managed care services to Medicaid beneficiaries enrolled in the State of Indiana's Hoosier Care Connect program. The State shall contract on a statewide basis with managed care entities (MCEs) with a demonstrated capacity to actively manage and coordinate care for low income disabled populations. This includes specific experience and demonstrated success in operating care coordination programs for low income individuals with significant health needs. MCEs must meet all applicable requirements of Medicaid managed care organizations under Sections 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438, and IC 12-15 as may be amended.

1.0 Background

The Indiana Family and Social Services Administration (FSSA) through the Office of Medicaid Policy and Planning (OMPP) manages the Hoosier Care Connect program, which will serve approximately 90,000 Hoosiers. Hoosier Care Connect is a coordinated care program for Indiana's Medicaid enrollees with a disability who are not Medicare eligible and do not have an institutional level of care. The program also includes voluntary enrollment for wards, foster children, former foster children and children receiving adoption assistance.

Through the Hoosier Care Connect program, FSSA seeks to continue to improve the quality of care and health outcomes for members. This includes improved clinical and functional status, enhanced quality of life, improved member safety, enhanced member autonomy and adherence to treatment plans. In developing Hoosier Care Connect, FSSA seeks to achieve the following goals:

- Improve quality outcomes and consistency of care across the delivery system;
- Ensure enrollee choice, protections and access;
- Coordinate care across the delivery system and care continuum; and
- Provide flexible person-centered care.

2.0 Administrative Requirements

2.1 State Licensure

Prior to the Contract effective date, and as verified in the readiness review described in Section 2.13, the Contractor must be an Indiana licensed accident or sickness insurer or an Indiana licensed health maintenance organization (HMO).

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

2.2 National Committee for Quality Assurance (NCQA) Accreditation

The Contractor must be accredited by the NCQA pursuant to IC 12-15-12-21. If not already NCQA accredited, the Contractor shall initiate the health plan accreditation process immediately following the Contract start date and must achieve accreditation prior to April 31, 2022, unless the Contractor requests an extension which is granted solely at FSSA's discretion. When accreditation standards conflict with the standards set forth in the Contract or State law, the Contract or State law prevails unless the accreditation standard is more stringent.

2.3 Subcontracts

The term "subcontract(s)" includes contractual agreements between the Contractor and health care providers or other ancillary medical providers. Additionally, the term "subcontract(s)" includes contracts between the Contractor and another prepaid health plan, physician hospital organization, dental benefits manager, transportation broker or any entity that performs delegated activities related to the Contract and any administrative entities not involved in the actual delivery of medical care.

In accordance with 42 CFR 438.230, the Contractor is accountable for any functions and responsibilities that are delegated to a subcontractor and is responsible for the performance of any obligations that may result from the Contract. Subcontractor agreements do not terminate the legal responsibility of the Contractor to the State to ensure that all activities under the Contract are carried out. Prior to delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. All subcontracts must be supported by a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. The Contractor shall also ensure all written subcontracts meet the requirements of 42 CFR 434.6 and shall incorporate by reference the applicable terms and conditions of the Contract. In accordance with IC 12-15-30-5, subcontracts, including provider agreements, cannot extend beyond the term of the Contract between the Contractor and the State but may automatically renew consistent if the Contract is re-awarded by subsequent procurement. A reference to this provision and its requirements must be included in all provider agreements and subcontracts.

FSSA must approve all subcontractors, with the exception of network healthcare providers or ancillary medical providers, and any change in subcontractors or material change to subcontracting agreements. The Contractor must give FSSA a written request and submit a draft contractor or model provider agreement at least sixty (60) calendar days prior to the use of a subcontractor. If the Contractor makes subsequent changes to the duties included in the subcontractor agreement, it must notify FSSA sixty (60) calendar days prior to the revised effective date and submit the amendment for review and approval. FSSA must approve changes in vendors for any previously approved subcontracts. FSSA may waive its right to review subcontracts and material changes to subcontracts. Such waiver shall not constitute a waiver of any subcontract requirement.

The Contractor must have policies and procedures to audit and monitor subcontractors' data, data submission and performance and must implement oversight mechanisms to monitor performance and compliance with Contract requirements. Further, the Contractor shall monitor the subcontractor's performance on an ongoing basis. Formal reviews of subcontractors, excluding network healthcare providers or ancillary medical providers, must be conducted at least quarterly. FSSA reserves the right to audit subcontractor data and conduct onsite visits. Whenever deficiencies or areas of improvement are identified, the Contractor and subcontractor shall take corrective action. The Contractor shall provide to FSSA the findings of all subcontractor performance monitoring and reviews upon request and shall notify FSSA any time a subcontractor is placed on corrective action. Additionally, FSSA shall establish and provide to the Contractor, through the Reporting Manual, any reporting requirements for incorporating subcontractor performance into the reports to be submitted to FSSA. The Contractor must integrate subcontractors' financial and performance data (as appropriate) into the Contractor's Information Technology (IT) systems to accurately and completely report Contractor performance and confirm compliance with the Contract.

The Contractor shall provide that all subcontracts related to the Contract, including, but not limited to subcontracts with other prepaid health plans, physician hospital-organizations, any entity performing delegated activities related to the Contract and any administrative entity not

involved in the delivery of medical care, indemnify and hold harmless the State, its officers and employees from and against all claims, causes of action, damages, expenses, judgments and costs, including court costs, attorney's fees and other expenses ("Losses"), directly or indirectly arising out of or in any way connected with any liability asserted by a third party related to injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of the Contractor and/or the subcontractors. The Contractor agrees to indemnify and hold harmless the State, its officers and employees from all Losses arising out of Contractor's failure to include this required indemnity in its subcontracts. Notwithstanding the foregoing, this indemnification requirement does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor. The subcontracts must further provider that the State shall not provide such indemnification to the subcontractor.

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

- A statement of revenues and expenses;
- A balance sheet;
- Cash flows and changes in equity/fund balance; and
- Incurred but not received (IBNR) estimates.

At least annually, the Contractor must obtain the following additional information from the subcontractor and use this information to monitor the subcontractor's performance: (i) audited financial statements including statement of revenues and expenses; (ii) balance sheet; (iii) cash flows and changes in equity/fund balance; and (iv) an actuarial opinion of the IBNR estimates. The Contractor shall make these documents available to FSSA upon request.

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

The Contractor is prohibited from subcontracting with providers who have been excluded from the federal government or by the Indiana Health Coverage Program (IHCP) for fraud or abuse. The Contractor shall be responsible for checking the lists of providers currently excluded by the state and the federal government every thirty (30) calendar days. The federal list is available at: http://exclusions.oig.hhs.gov. As described in Section 6.0, all network providers must be IHCP enrolled providers. The Contractor shall ensure when the IHCP disenrolls a provider, the Contractor also terminates the provider agreement for the Hoosier Care Connect program.

While the Contractor may choose to subcontract claims processing functions, or portions of those functions, with a state-approved subcontractor, the Contractor shall demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral providers, and will not result in confusion to the provider community about where to submit claims for payments. For example, the Contractor may elect to establish one post office box address for submission of all out-of-network provider claims. If different

subcontracting organizations are responsible for processing those claims, it is the Contractor's responsibility to ensure that the subcontracting organizations forward claims to the appropriate processing entity. Use of a method such as this will not lengthen the timeliness standards discussed in Section 8.5.3. In this example, the definition of "date of receipt" is the date of the claim's receipt at the post office box. If the Contractor uses subcontractors to provide direct services to members, such as behavioral health services, the subcontractors must meet the same requirements as the Contractor, and the Contractor must demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The Contractor 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.

2.4 Financial Stability

The Contractor must be licensed and in good standing to provide health insurance coverage in the State and must comply with all applicable State and Federal insurance regulations. FSSA and the Indiana Department of Insurance (IDOI) will monitor the Contractor's financial performance. FSSA will include IDOI findings in their monitoring activities. FSSA must be copied on required filings with IDOI, and the required filings must break out financial information for the Hoosier Care Connect line of business. The financial performance reporting requirements are listed in Section 9.1 and are further described in the Reporting Manual.

2.4.1 Solvency

The Contractor must maintain a fiscally solvent operation per federal requirements and IDOI's requirements for a minimum net worth and risk-based capital. The Contractor must have a process in place to review and authorize contracts established for reinsurance. The Contractor must have a process in place to review and authorize contracts established for third party liability, if applicable. The Contractor must comply with the federal requirements for protection against insolvency pursuant to 42 CFR 438.116. These requirements provide that, unless the Contractor is a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act, as amended), the Contractor must:

- Provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its members will not be liable for the Contractor's debts if the entity becomes insolvent; and

- Meet the solvency standards established by the State for private HMOs, or be licensed or certified by the State as a risk-bearing Managed Care Organization (MCO).

2.4.2 Insolvency and Receivership

The Contractor must obtain continuation of coverage insurance (insolvency insurance) to continue plan benefits for members until the end of the period for which premiums have been paid. This coverage must extend to members in acute care hospitals or nursing facility settings when the Contractor's insolvency occurs during the member's inpatient stay. The Contractor must continue to reimburse for its member's care under those circumstances (i.e., inpatient stays) until the member is discharged from the acute care setting or nursing facility.

2.4.3 Reinsurance

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

- Agreements and Coverage
  - The attachment point shall be equal to or less than $200,000 and shall apply to all services, unless otherwise approved by OMPP. The Contractor electing to amend commercial reinsurance agreements with an attachment point greater than $200,000 must provide a justification in its proposal or submit justification to OMPP in writing at least one hundred and twenty (120) calendar days prior to the policy renewal date or date of the proposed change. The Contractor must receive approval from OMPP before changing the attachment point.
  - The Contractor's co-insurance responsibilities above the attachment point shall be no greater than twenty percent (20%).
  - Reinsurance agreements shall transfer risk from the Contractor to the reinsurer.
  - The reinsurer's payment to the Contractor shall depend on and vary directly with the amount and timing of claims settled under the reinsured contract. Contractual features that delay timely reimbursement from the reinsurer are not acceptable.
  - The Contractor shall obtain continuation of coverage insurance (insolvency insurance) to continue plan benefits for members until the end of the period for which premiums have been paid. This coverage shall extend to members in acute care hospitals or nursing facility settings when the Contractor's insolvency occurs during the member's inpatient stay. The Contractor shall continue to reimburse for its member's care under those circumstances (i.e., inpatient stays) until the member is discharged from the acute care setting or nursing facility.
- Requirements for Reinsurance Companies
  - The Contractor shall submit documentation that the reinsurer follows the National Association of Insurance Commissioners' (NAIC) Reinsurance Accounting Standards.
  - The Contractor shall be required to obtain reinsurance from insurance organizations that have Standard and Poor's claims-paying ability ratings of "AA" or higher and a Moody's bond rating of "A1" or higher, unless otherwise approved by OMPP in writing.
- Subcontractors
  - Subcontractors' reinsurance coverage requirements must be clearly defined in the reinsurance agreement.
  - Subcontractors should be encouraged to obtain their own stop-loss coverage with the above-mentioned terms.

- If subcontractors do not obtain reinsurance on their own, the Contractor is required to forward appropriate recoveries from stop-loss coverage to applicable subcontractors.

2.4.4 Performance Bond Requirements

The Contractor must provide a performance bond of standard commercial scope issued by a surety company registered with the IDOI, in the amount of $1,000,000, or other evidence of financial responsibility to guarantee performance by the Contractor of its obligations under the Contract. This requirement applies specifically to the Hoosier Care Connect program. If the Contractor also delivers services to Indiana Medicaid enrollees under a separate contract with the State, a separate performance bond is required for the Hoosier Care Connect program. The State reserves the right to increase the financial responsibility requirements set forth in this section if enrollment levels indicate the need to do so. In the event of a default by the Contractor, the State must, in addition to any other remedies it may have under the Contract, obtain payment under the performance bond or other arrangement for the purposes of the following:

- Reimbursing the State for any expenses incurred by reason of a breach of the Contractor's obligations under the Contract, including, but not limited to, expenses incurred after termination of the Contract for reasons other than the convenience of the State.

- Reimbursing the State for costs incurred in procuring replacement services.

2.4.5 Financial Accounting Requirements

The Contractor shall maintain fiscal records, including its books, audit papers, documents, and any other evidence of accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of the Contract. Furthermore, the Contractor shall maintain all financial accounting records in accordance with IDOI requirements. Accounting records shall be maintained separately for the Contractor's Hoosier Care Connect line of business and provided to FSSA as requested. If the Contractor does not provide Hoosier Care Connect specific information, FSSA may terminate the Contract. As applicable, the Contractor shall incorporate the performance and financial data of risk-bearing subcontractors.

The Contractor shall make full disclosure of ownership and control information for the Contractor, any subcontracting entities or providers as required by 42 CFR 455.100 through 455.106. The Contractor must notify FSSA of any person or corporation with five percent (5%) or more of ownership or controlling interest in the Contractor and must submit financial statements for these individuals or corporations. Additionally, annual audits must include an annual actuarial opinion of the Contractor's IBNR claims specific to the Hoosier Care Connect program.

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

Copies of any accounting records pertaining to the Contract must be made available by the Contractor within ten (10) calendar days of receiving a written request from the State for specified records. If such original documentation is not made available as requested, the Contractor must provide transportation, lodging and subsistence at no cost, for all

state and/or federal representatives to carry out their audit functions at the principal offices of the Contractor or other locations of such records. FSSA, IDOI 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 insofar as they relate to transactions with any department, board, commission, institution or other state or federal agency connected with the Contract.

The Contractor must maintain financial records pertaining to the Contract, including all claims records, for three (3) years following the end of the federal fiscal year during which the Contract is terminated, or when all state and federal audits of the Contract have been completed, whichever is later, in accordance with 45 CFR 75.361.

Accounting records pertaining to the Contract must be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the Contract if the litigation has not terminated within the three (3) year period. Financial records should address matters of ownership, organization and operation of the Contractor's financial, medical and other record keeping systems.

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

- Tangible net equity (TNE) or risk-based capital at balance sheet date;
- Cash and cash equivalents;
- Claims payment, IBNR, reimbursement, fee-for-service claims, provider contracts by line of business;
- Appropriate insurance coverage for medical malpractice, general liability, property, worker's compensation and fidelity bond, in conformance with state and federal regulations;
- Revenue sufficiency by line of business /group and program;
- Renewal rates or proposed rates by line of business;
- Corrective action plans and implementation records of corrective action taken to remedy noncompliance with any financial requirements, if applicable;
- Financial, cash flow and medical expense projections by line of business;
- Underwriting plan and policy by line of business;
- Premium receivable analysis by line of business;
- Affiliate and inter-company receivables;
- Current liability payables by line of business;
- Medical liabilities by line of business; and
- Copies of any correspondence to and from the IDOI.

2.4.6 Insurance Requirements

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

Prior to the Contract start date, the Contractor must also obtain from an insurance company duly authorized to do business in the State, professional liability (malpractice) insurance for the Contractor and its Medical Director, as defined in IC 34-18-4-1. The Contractor shall also obtain workers' compensation insurance and comprehensive liability insurance.

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

2.5 Maintenance of Records

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

2.6 Disclosures

The Contractor shall provide full disclosure of information on persons convicted of crimes as required by 42 CFR 455.106. Additionally, the Contractor shall provide full disclosure of business transactions, as required by 42 CFR 455.105 upon request by FSSA. Any Contractor that is not a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act) must disclose to FSSA information on certain types of transactions they have with a "party in interest," as defined in the Public Health Service Act. (See §§1903(m)(2)(A)(viii) and 1903(m)(4) of the Social Security Act.) The reporting requirements in Sections 2.6.1 and 2.6.2 will apply to all Contractors in the same manner that they apply to federally qualified HMOs under the Public Health Service Act.

2.6.1 Definition of a Party in Interest

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

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

- Any entity in which a person described in the paragraph above is director or officer; is a partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the HMO;

- Any person directly or indirectly controlling, controlled by or under common control with an HMO; and

- Any spouse, child or parent of an individual described above.

2.6.2 Types of Transactions Which Must Be Disclosed

Business transactions which must be disclosed include:

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

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

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

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

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

2.7 Debarred Individuals

The contractor shall have policies and procedures in place to routinely monitor staff positions and subcontractors for individuals debarred or excluded.

The Contractor shall be required to disclose to the OMPP PI Section information required by 42 CFR 455.106 regarding the Contractor’s staff and persons with an ownership/controlling interest in the Contractor that have been convicted of a criminal offense related to that person’s involvement in Medicare/Medicaid or Title XIX programs.

In accordance with 42 CFR 438.610, the Contractor 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; and

- 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 Contractor, persons with beneficial ownership of five percent (5%) or more of the Contractor's equity, or persons with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

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

2.8 Medical Loss Ratio

The MLR shall be calculated as follows:

The Contractor shall calculate and submit to FSSA its Medical Loss Ratio (MLR). The calculation must fully comply with 42 CFR 438.8 and CMS guidance. In addition, the State provides the following clarifications:

- The MLR calculation shall be performed separately for each MLR reporting year.

- The MLR calculation shall be performed separately for each program. The MLR for the Hoosier Care Connect 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 Contractor shall maintain, at minimum, a MLR of ninety percent (90%) for the Hoosier Care Connect line of business.

The Contractor is required to submit MLR reporting as described in the MCE Reporting Manual for Hoosier Care Connect.

FSSA shall recoup excess capitation paid to the Contractor in the event that the Contractor's MLR is less than ninety percent (90%) for the Hoosier Care Connect line of business.

2.9 Health Insurance Providers Fee

Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers ("Annual Fee"). The Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during the Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Services. The State, following its review and acceptance of the Contractor's Adjusted Fee, will retroactively adjust the Contractor's capitation rates to provide reimbursement for the Contractor's Adjusted Fee.

To claim reimbursement for the Contractor's Adjusted Fee the Contractor must submit a certified copy of its full Annual Fee assessment within sixty (60) days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under the Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums under the Contract and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either the Contractor's Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

2.10 Administrative and Organizational Structure

The Contractor shall have in place an organizational and operational structure capable of fulfilling all Contract requirements. This structure must support collection and integration of data across the Contractor's delivery system and internal functional units to accurately report the Contractor's performance. The Contractor must have in place sufficient administrative and clinical staff and organizational components to achieve compliance with Contract requirements and performance standards. The Contractor must manage the functional linkage of the following major operational areas:

- Administrative and fiscal management;
- Member services;
- Provider services;
- Marketing;
- Provider enrollment;
- Network development and management;
- Quality management and improvement;

- Utilization management;
- Clinical assessment, disease management, care management and complex case management;
- Behavioral and physical health;
- Information Technology systems;
- Performance data reporting and encounter claims submission;
- Claims payments; and
- Grievances and appeals.

2.10.1 Staffing

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

The Contractor must maintain job descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to: education, professional credentials, work experience and membership in professional or community associations.

2.10.2 Key Staff

The Contractor must employ sufficient staff to achieve compliance with contractual requirements and performance metrics. The Contractor shall set up and maintain a business office or work site within five miles of downtown Indianapolis, Indiana, from which, at a minimum, key staff members and care managers physically perform the majority of their daily duties and responsibilities, and a major portion of the Contactor's operations take place. The Contractor shall be responsible for all costs related to securing and maintaining the facility for interim start-up support and the subsequent operational facility.

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

In addition, the Contractor must maintain a backup personnel plan, including a discussion of the staffing contingency plan for (i) the process for replacement of personnel in the event of a loss of key staff or others before or after signing a Contract; (ii) allocation of

additional resources to the Contract in the event of an inability to meet a performance standard; (iii) replacement of staff with key qualifications and experience and new staff with similar qualifications and experience; (iv) the time frame necessary for obtaining replacements; and (v) the method of bringing replacement or additions up to date regarding the Contract.

Upon award of the Contract, the Contractor shall deliver the final staffing plan within thirty (30) calendar days after notice of award; such plan will include a resume for each proposed key staff person outlined below for acceptance by FSSA. FSSA reserves the right to approve or disapprove all initial and replacement key staff prior to their assignment to the Hoosier Care Connect project. FSSA shall have the right to require that the Contractor remove any individual (whether or not key staff) from assignment to the project. If the Contractor desires to change the individual in a key staff position at any point in the Contract, the Contractor shall submit the request and the resume(s) of the candidate(s) to FSSA for acceptance.

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

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

The key staff positions required under the Contract include:

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

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

- Compliance Officer – The Contractor must employ a Compliance Officer who is accountable to the Contractor's executive leadership and dedicated full-time to the Hoosier Care Connect program. This individual will be the primary liaison with the State (or its designees) to facilitate communications between FSSA, the State's contractors and the Contractor's executive leadership and staff. This individual must maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the Hoosier Care Connect program. It is the responsibility of the Compliance Officer to coordinate reporting to the State as defined in Section 9.0 and to review the timeliness, accuracy and completeness of reports and data submissions to the State. The Compliance Officer, in close coordination with other key staff, has primary responsibility for ensuring all Contractor functions are in compliance with the terms of the Contract. The Compliance Officer shall meet with the OMPP Surveillance and Utilization Review Unit (SUR) on a quarterly basis.

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

- Medical Director – The Contractor must employ the services of a Medical Director who is an IHCP provider. The Medical Director must be dedicated full-time to the Hoosier Care Connect program. The Medical Director must oversee the development and implementation of the Contractor's disease management, care management and complex case management programs; oversee the development of the Contractor's clinical practice guidelines; review any potential quality of care problems; oversee the Contractor's clinical management program and programs that address special needs populations; oversee health screenings and assessments; serve as the Contractor's medical professional interface with the Contractor's healthcare providers; and 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. The Medical Director, in close coordination with other key staff, is responsible for ensuring that the medical management and quality management components of the Contractor's operations are in compliance with the terms of the Contract. The Medical Director shall attend all FSSA quality meetings, including the Quality Strategy Committee and Subcommittee meetings. If the Medical Director is unable to attend an FSSA quality meeting, the Medical Director shall designate a representative to take his or her place. This representative must report back to the Medical Director on the meeting's agenda and action items.

- Member Services Manager – The Contractor must employ a Member Services Manager. The Member Services Manager must, at a minimum, be responsible for directing the activities of the Contractor's member services, including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs and development, approval and distribution of member materials. The Member Services Manager must oversee the interface with the Enrollment Broker regarding such issues as member eligibility, enrollment and disenrollment. The Member Services Manager must provide an orientation and on-going training for member services helpline representatives, at a minimum, to support accurately informing members of how the Contractor operates, availability of covered services, benefit limitations, health screenings, Emergency services, preventive and enhanced services, disease management, care management and complex case management services and member grievances and appeals procedures. The Member Services Manager, in close coordination with other key staff, is responsible for ensuring that all of the Contractor's member services operations are in compliance with the terms of the Contract. For more information regarding the member services program requirements, see Section 4.0.

- Provider Services Manager – The Contractor must employ a Provider Services Manager who is dedicated full-time to the Hoosier Care Connect program. The Provider Services Manager must, at a minimum, be responsible for the provider services helpline performance, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials and developing outreach programs. The Provider Services Manager oversees the process of providing information to the State fiscal agent regarding the Contractor's provider network. The Provider Services Manager, in close coordination with other key staff, is responsible for ensuring that all of the Contractor's provider services operations are in compliance with the terms of the Contract. For more information regarding the provider services program requirements, see Section 6.0.

- Quality Management Manager – The Contractor must employ a Quality Management Manager. The Quality Management Manager must, at a minimum, be responsible for directing the activities of the Contractor's quality management staff, under the direct supervision of the Medical Director, in monitoring and auditing the Contractor's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Quality Management Manager must assist the Contractor's Compliance Officer in overseeing the activities of the Contractor's operations to meet the State's goal of providing health care services that improve the health status and health outcomes of Hoosier Care Connect members. For more information regarding the quality management requirements, see Section 7.1.

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

- Utilization Management Manager – The Contractor must employ a Utilization Management Manager who is dedicated full-time to the Hoosier Care Connect program. The Utilization Management Manager must, at a minimum, be responsible for directing the activities of the utilization management staff. With direct supervision by the Medical Director, the Utilization Management Manager must direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, appropriate utilization of health care services, continuity of care, care coordination and other clinical and medical management programs. The Utilization Management Manager (or Claims Manager, as applicable) shall work with the Special Investigation Unit (SIU) Manager to assure that service billing and utilization issues are documented and reported to the SIU, and matters requiring SIU review or investigation shall be timely submitted within five (5) business days to enable recovery of overpayments or other appropriate action. For more information regarding the utilization management requirements, see Section 7.3.

- Behavioral Health Manager **–** The Contractor must employ a Behavioral Health Manager who is dedicated full-time to the Hoosier Care Connect program. The Behavioral Health Manager is responsible for ensuring that the Contractor's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager 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 and Subcommittee meetings and in the Mental Health Quality Assurance Committee. The Behavioral Health Manager must work closely with the Contractor's network development and provider relations staff to develop and maintain the behavioral health network and ensure that there is communication, collaboration and coordination with the physical health provider network. The Behavioral Health Manager shall collaborate with key staff to ensure the coordination of physical and behavioral health care as set forth in Section 3.10.2 and coordination with Medicaid Rehabilitation Option (MRO) and 1915(i) services as set forth in Sections 3.12.1 and 3.12.2. 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 his or her designee, shall be the primary liaison with behavioral health community resources, including Community Mental Health Centers (CMHCs), and be responsible for all reporting related to the Contractor's provision of behavioral health services.

  If the Contractor subcontracts with a behavioral health organization (BHO) to provide behavioral health services, the Behavioral Health Manager will continue to work closely with the Contractor's other managers to provide monitoring and oversight of the BHO and to ensure the BHO's compliance with the Contract.

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

- Data Compliance Manager **-** The Contractor must employ a Data Compliance Manager. The Data Compliance Manager will provide oversight to ensure the Contractor's data conform to FSSA 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 health care data and health care data exchange standards. The Data Compliance Manager will manage data quality, change management and data exchanges with FSSA or its designee(s). The Data Compliance Manager shall be responsible for data quality and verification, data delivery, change management processes used for data extract corrections and modification and enforcement of data standards and policies for data exchanges to FSSA as defined by the State. The Data Compliance Manager shall coordinate with the State to implement data exchange requirements.

- Pharmacy Director – The Contractor must employ a Pharmacy Director who is an

Indiana licensed pharmacist dedicated full-time to the Contractor's Indiana Medicaid product lines. The Pharmacy Director shall oversee all pharmacy benefits under the Contract as outlined in Section 3.8. This individual shall represent the Contractor at meetings of the State's Drug Utilization Review (DUR) Board meetings and the Mental Health Quality Advisory Committee (MHQAC). The State prefers the Pharmacy Director attend Therapeutics Committee meetings when applicable. If the Contractor subcontracts with a Pharmacy Benefits Manager (PBM), the Pharmacy Director shall be responsible for oversight and Contract compliance of the PBM.

- Member Advocate/Non-Discrimination Coordinator – The Contractor must employ a Member Advocate/Non-Discrimination Coordinator dedicated full-time to the Hoosier Care Connect 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 required in Section 4.7.1. This individual shall also be responsible for the Contractor's compliance with federal and state civil rights laws, regulations, rules and policies, including but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) and the Age Discrimination Act. This position also serves as an ombudsperson for member issues or needs when a member needs assistance navigating a health plan process or decision.

- Grievance and Appeals Manager – The Contractor shall employ a Grievance and Appeals Manager responsible for managing the Contractor's grievance and appeals process. This individual shall be responsible for ensuring compliance with processing timelines and policy and procedure adherence as outlined in Section 4.12.

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

- Care Management Manager - The Contractor must employ a full-time Care Management Manager dedicated to the Hoosier Care Connect program. This Manager must oversee the disease management, care management, complex case management and Right Choices Program (RCP) functions as outlined in Section 5.0. The Care Management Manager must, at a minimum, be a registered nurse or similar medical professional with extensive experience in providing care coordination to a variety of populations. This individual will work directly under the Contractor's Medical Director to develop, expand and maintain the care management program. The individual will be responsible for overseeing care management teams, care plan development and care plan implementation. The Care Management Manager will be responsible for directing the activities of the care managers. These responsibilities extend to physical and behavioral health care services. This individual will work with the Medical Director, Provider and Member Services Managers, and with State staff as necessary, to communicate to providers and members. The Care Management Manager will provide input, as requested by the State, at State-level meetings.

- Indiana Department of Child Services (DCS) Liaison - The Contractor must employ a full-time Liaison to Indiana DCS, dedicated to overseeing the Hoosier Care Connect wards and foster children population. The Liaison shall be responsible for coordinating with the two (2) designated Indiana DCS staff to promptly resolve any issues identified by the Contractor, Indiana DCS, or the State that arise related to the program or to the individual healthcare of a member. The Liaison shall also be responsible for aiding in the transition of the Hoosier Care Connect wards and foster children population if the State determines in its best interest to address the healthcare needs of this population via a different channel.

2.10.3 Other Required Staff Positions

In addition to the key staff positions outlined in Section 2.10.2, the Contractor is required to employ the following staff:

- 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;

- A sufficient number of care management staff based within Indiana to meet the requirements outlined in Section 5.0. Care managers for complex case management and RCP described in further detail in Sections 5.2.3, 5.2.4 and 5.2.5, must be licensed physician assistants, registered nurses, therapists, or social workers and have training, expertise and experience in providing case management and care coordination services for individuals, including specialized populations such as wards and foster children, with the conditions prevalent in the Hoosier Care Connect population; and

- A Transition Coordinator responsible for oversight of the continuity of care requirements outlined in Section 3.15. This individual shall be dedicated to oversight of all member transitions in and out of the Hoosier Care Connect program and the Contractor's enrollment. The Transition Coordinator shall be responsible for ensuring the transfer and receipt of all outstanding prior authorization decisions, utilization management data and clinical information such as disease management, care management and complex case management notes.

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

2.10.4 Suggested Staff Positions

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

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

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

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

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

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

- Member marketing and outreach staff to manage marketing and outreach efforts for the Hoosier Care Connect program.

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

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

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

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

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

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

2.10.5 Staff Training and Qualifications

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

- An overview of the Hoosier Care Connect program & associated policies and procedures, including updates whenever changes occur;
- Contract requirements and state and federal requirements specific to job functions;
- In accordance with 42 CFR 422.128, training on the Contractor's policies and procedures on advance directives;
- Initial and ongoing training on identifying and handling quality of care concerns;
- Cultural sensitivity training;
- Training on fraud and abuse and the False Claims Act;
- Health Insurance Portability and Accountability Act (HIPAA) training;
- Management of IT systems;
- Clinical protocol training for all clinical staff;
- Training for care management staff in trauma-informed care, safety, security, and needs of the wards and foster children population;
- Utilization management staff shall receive ongoing training regarding interpretation and application of the Contractor's utilization management guidelines. The ongoing training shall, at minimum, be conducted on a quarterly basis and as changes to the Contractor's utilization management guidelines and policies and procedures occur;
- Assessment processes, person-centered planning and population specific training relevant to the populations enrolled in the Hoosier Care Connect program for all care managers. The Contractor shall also ensure all applicable subcontractors provide such training to their relevant staff;
- Training and education to understand abuse, neglect, exploitation and prevention including the detection, reporting, investigation and remediation procedures and requirements; 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 State-developed Hoosier Care Connect Policies and Procedures Manual, as may be amended by FSSA from time to time, shall be provided to the Contractor's entire staff and shall be incorporated into all training programs for staff responsible for providing services

under the Contract. Training materials must be updated on a regular basis to reflect any program changes. The Contractor shall maintain documentation to confirm staff training, curriculum, schedules and attendance and provide to FSSA upon request and during regular on-site visits.

2.11 FSSA Meeting Requirements

FSSA shall conduct meetings and collaborative workgroups for the Hoosier Care Connect program. The Contractor must comply with all meeting requirements established by FSSA, and is expected to cooperate with FSSA and/or its designees in preparing for and participating in these meetings. The Contractor shall also participate in meetings and proceedings with external entities as directed by FSSA, including but not limited to, the DUR Board, MHQAC, Medicaid Advisory Committee, Therapeutics Committee, Indiana Psychotropic Medication Advisory Committee and legislative hearings. FSSA may also require the participation of subcontracted entities in other instances, as determined necessary. All expenses for attendance at all meetings are considered to be included in the total bid price and shall be at no additional cost to FSSA. FSSA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary.

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

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

2.12 Maintenance of Written Policies and Procedures

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

2.13 Participation in Readiness Review

The Contractor shall undergo and must pass a two (2)-phase readiness review process and be ready to assume responsibility for contracted services upon the Contract effective date as described in further detail in the Readiness Review requirements and documentation. The Contractor shall maintain a detailed implementation plan, to be approved by FSSA, which identifies the elements for implementing the proposed services which include, but are not limited to, the Contractor's tasks, staff responsibilities, timelines and processes that will be used to ensure contracted services begin upon the Contract effective date. In addition to

submitting the implementation plan with the proposal, the Contractor may be required to submit a revised implementation plan for review as part of the Readiness Review.

2.14 Confidentiality of Member Medical Records and Other Information

The Contractor shall have written policies and procedures pertaining to maintaining the confidentiality of all medical records and other pertinent information, including, but not limited to, health and enrollment information. In accordance with 42 CFR 438.224, the Contractor must ensure that member medical records, as well as any other health and enrollment information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the HIPAA Privacy Rule (see 45 CFR parts 160 and 164, subparts A and E). The Contractor must also comply with all other applicable state and federal privacy and confidentiality requirements, including but not limited to 42 CFR Part 2.

2.15 Material Change to Operations

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

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

2.16 Response to State Inquiries & Requests for Information

FSSA may, at any time during the term of the Contract, request financial or other information from the Contractor. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from FSSA as proprietary. Information designated as confidential may not be disclosed by FSSA without the prior written consent of the Contractor except as required by law. If the Contractor believes the requested information is confidential and may not be disclosed to third parties, the Contractor shall provide a detailed legal analysis to FSSA, setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

The FSSA may directly receive inquiries and complaints from external entities, including but not limited to, providers, members, legislators or other constituents which require Contractor research, response and resolution. This also includes internet quorum (IQ) inquiries. IQ inquiries typically include member, provider and other constituent concerns and require a prompt response. The Contractor shall respond to IQ and other inquiries within the timeframe set forth by FSSA. When forwarding an IQ inquiry to the Contractor for a response, FSSA shall designate that the inquiry is an IQ inquiry and will identify when the Contractor's response is due. Unless an alternative deadline is identified by FSSA for a specific IQ inquiry, IQ inquiries must be resolved in no more than five (5) business days. Failure by the Contractor to provide a timely and satisfactory response to IQ inquiries will subject the Contractor to the liquidated damages set forth in Contract Exhibit 2 Contract Compliance and Pay for Outcomes.

2.17 Dissemination of Information

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

2.18 FSSA Ongoing Monitoring

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

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

2.19 Future Program Guidance

In addition to complying with the Hoosier Care Connect Policies and Procedures Manual, the Contractor must operate in compliance with future program manuals, guidance and policies and procedures, as well as any amendments thereto, at no additional cost to FSSA. Future modifications that have a significant impact on the Contractor's responsibilities, as set forth in this Scope of Work, will be made through the Contract amendment process.

2.20 Dual Eligible Special Needs Plans (D-SNPs) Requirements

The Contractor shall have Centers for Medicare & Medicaid Services (CMS) approval to operate a statewide Dual Eligible Special Needs Plan (D-SNP) by April 1, 2022. The Contractor seeking D-SNP status for the first time shall be aware of the following general timeline as it intersects with the Hoosier Care Connect program.

CMS continues to develop this timeline therefore it is subject to change without notice to the State. CMS will provide more specific due dates as it gets closer to the time period in the general timeline described below. The Contractor is responsible for monitoring CMS information regarding dates of submission for D-SNP related documentation.

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2020, Nov	Contractor submits Notice of Intent to Apply (NOIA) to CMS for CY 2022
2021, Jan-Feb	Contractor submits the following to CMS: • MA and Part D application • Initial SNP application • Model of Care
2021, Apr 1	**Hoosier Care Connect contracts implemented**
2021, May	CMS/NCQA issues MOC renewal terms of one, two, or three years
2021, Jun	Contractor submits the following to CMS for 2022: • Plan Benefit Package (PBP) • Completed Bid Pricing Tool (PBT) to CMS for the upcoming year Both should be consistent with State requirements
2021, July	**Contractor submits its State Medicaid Agency Contract (SMAC) to CMS for CY 2022. Contract must include the following.** **New Provisions (due to be implemented CY 2021):** • Provision of Medicaid LTSS and/or Medicaid behavioral health benefits either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP; OR • Process to share information with the State or the State's designee (such as a Medicaid managed care organization or Medicaid care manager), on hospital and SNF admissions of high-risk individuals who are enrolled in the D-SNP. **In addition to the minimum requirements per 42 CFR 422.107:** • The D-SNP's responsibility, including financial obligations, to provide or arrange for Medicaid benefits. • The categories of dually eligible beneficiaries eligible to be enrolled under the SNP (e.g., full benefit, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), etc.). • The Medicaid benefits covered under the SNP. • The cost sharing protections covered under the SNP. • The requirements to identify and share information on Medicaid provider participation. • The procedural requirements for the verification of enrollees' eligibility for both Medicare and Medicaid. • The service area covered by the SNP. The contract period for the SNP.
2021, Sept	CMS issues SNP approval/denial notices
2022, April 1	**Hoosier Care Connect Contractor D-SNPs implemented**

2.21 Capitation Related to a Vacated Program

Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must not implement that part after the effective date of the loss of program authority. The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor received capitation payments that included costs specific to a program or activity no longer authorized by law prior to the effective date of the loss of authority

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

3.0 Covered Benefits

The Hoosier Care Connect program includes all Indiana Health Coverage Programs covered services as detailed in 405 IAC 5. Contract Exhibit 3 Program Description and Covered Benefits provides a general description of the covered benefits. The Contractor must cover, at minimum, all benefits and services deemed medically necessary and reasonable and covered under the Hoosier Care Connect program in accordance with the terms of the Contract. A covered service is medically necessary if, in a manner consistent with accepted standards of medical practice, it is reasonably expected to:

- Prevent or diagnose the onset of an illness, injury, condition, primary disability or secondary disability.
- Cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury or disability.
- Reduce or ameliorate the pain or suffering caused by an illness, injury, condition or disability.

The Contractor shall comply with sections 1903(i)(16), 1903(i)(17), and 1903(i)(18) of the Social Security Act and is prohibited from paying for items or services (other than an Emergency item or service, not including items or services furnished in an Emergency room or a hospital):

- With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.
- With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State plan.
- With respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State on a continuing basis a surety bond as specified under paragraph (7) of section 1861(o) of the Social Security Act.

In accordance with 42 CFR 438.210(a)(3), the Contractor must furnish covered services in an amount, duration or scope reasonably expected to achieve the purpose for which the services are furnished. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. In instances where the Contractor pays for a service provided to a Hoosier Care Connect member, the Contractor shall exclude the amount of the required copayment from the rates paid to the provider. Section 12 details which services require copayments and member copayment obligations. The Contractor may place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided the services can reasonably be expected to achieve their purpose. Further information on allowable and required utilization control measures is outlined in Section 7.3.

3.1 Self-Referral Services

In accordance with state and federal requirements, some covered benefits are available to members on a self-referral basis. These services shall not require a physician's referral or other authorization from the Contractor.

The Contractor must include self-referral providers in its contracted network. The Contractor may direct members to seek the services of the self-referral providers contracted in the Contractor's network. However, with the exception of behavioral health and routine dental services, the Contractor cannot require that the members receive such services from network providers. Members may self-refer to any IHCP provider qualified to provide the service(s). When members choose to receive self-referral services from IHCP-enrolled self-referral providers who do not have contractual relationships with the Contractor, the Contractor is responsible for payment to these providers up to the applicable benefit limits and at 98% of Indiana Medicaid fee-for-service (FFS) rates.

- Chiropractic services may be provided by a licensed chiropractor, enrolled as an IHCP provider, when rendered within the scope of the practice of chiropractic as defined in IC 25-10-1-1 and 846 IAC 1-1.

- Eye care services, except surgical services may be provided by any IHCP 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.

- Podiatric services may be provided by any IHCP 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 IHCP 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.

- Behavioral health services are self-referral if rendered by an in-network IHCP provider. Members may self-refer, within the Contractor's network, for behavioral health services not provided by a psychiatrist, including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers. Refer to Section 6.2.5 for additional information on the behavioral health provider network provider types.

- Family planning services under federal regulation 42 CFR 431.51(b)(2) 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. Family planning services also include sexually transmitted disease testing. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP provider qualified to provide the family planning service(s), including providers that are not in the Contractor's network. Members may not be restricted in choice of a family planning service provider, so long as the provider is an IHCP provider. The IHCP Provider Manual provides a complete and current list of family planning services.

- Emergency services are covered without the need for prior authorization or the existence of a Contractor contract with the Emergency care provider. Emergency services must be available twenty-four (24)-hours-a-day, seven (7)-days-a-week subject to the "prudent layperson" standard of an Emergency medical condition, as defined in

42 CFR 438.114 and IC 12-15-12. See Section 3.3 for more information.

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

- Diabetes self-management services are available on a self-referral basis to any IHCP provider when the member obtains the services from an IHCP self-referral provider. The State expects to include Diabetes Prevention Programs as a self-referral service in the future.

- Routine dental services may be provided by any in-network licensed IHCP dental provider who has entered into a provider agreement under IC 12-15-11.

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

The federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, referred to as EPSDT/HealthWatch in Indiana, is a preventive healthcare program designed to improve the overall health of Medicaid and CHIP-eligible individuals from birth through the month of their 21st birthday. EPSDT/HealthWatch services are available for all Hoosier Care Connect members through the month of their 21st birthday. EPSDT/HealthWatch is a required component of Indiana Health Coverage Programs (IHCP) managed care and fee-for-service (FFS) programs for members who fall within the age range for EPSDT. Specific rules about EPSDT/HealthWatch services can be found in the IHCP Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch Provider Reference Module and the Indiana Administrative Code 405 IAC 5-15. The Contractor must provide all covered EPSDT services in accordance with 405 IAC 5-15-8. In covering well-child visits, the Contractor shall follow the latest standards from the American Academy of Pediatrics (AAP) Bright Futures Guidelines. In addition, EPSDT services include the provision of medically necessary services to members less than twenty-one (21) years old in institutions for mental disease (IMDs).

The primary goal of EPSDT/HealthWatch is to ensure that children enrolled in IHCP receive age- appropriate comprehensive, preventive services. Early detection and treatment can reduce the risk of more costly treatment or hospitalization resulting from delayed treatment. See 405 IAC 5-15-8 and the IHCP Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch Provider Reference Module, provided in the Bidders' Library, for details regarding components and recommended frequency of HealthWatch screenings.

The Contractor shall educate pregnant women and work with providers to educate women about the importance of EPSDT screenings and encourage them to schedule preventive visits for their infants. Additionally, the Contractor shall ensure that members between the ages of nine (9) and twelve (12) months receive a blood lead screening test, and again at twenty-four (24) months of age. The Contractor shall also ensure that children who screen positive are enrolled in case management to ensure CDC recommended follow up and environmental investigation and management as indicated. If the member is at-risk for lead exposure, the initial screening should be performed at the 6-month visit and repeated at the 12-month and 24-month visits. Children between the ages of 36 months and 72 months of age must receive a blood lead screening if they have not been previously tested for lead poisoning. The Contractor will ensure that children with elevated blood lead levels are identified, their provider is notified and they receive the recommended follow-up treatment.

The Contractor shall work with Indiana DCS to ensure that all Hoosier Care Connect wards and foster children receive appropriate EPSDT/HealthWatch services at each age level and in a timely manner.

3.3 Emergency Services

The Contractor shall cover emergency services 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, which relates to emergency and post-stabilization services, and IC 12-15-12 (i.e., subject to the "prudent layperson" standard), shall be available twenty four (24)-hours-a-day, seven (7)-days-a-week.

The Contractor shall cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR 489.24, which sets special responsibilities for hospitals in emergency cases, provided to a member who presents to an emergency department with an emergency medical condition. The Contractor shall also comply with all applicable emergency services requirements specified in IC 12-15-12. The Contractor shall reimburse out-of-network providers at one-hundred percent (100%) of the Medicaid rate unless other payment arrangements are made. The Contractor is required to reimburse for the medical screening examination and facility fee for the screening but is not required to reimburse providers for services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition, unless the Contractor authorized this treatment. The Contractor shall pay the contracted or fee schedule rate for an observation stay, regardless of whether a related emergency department visit was determined emergent.

In accordance with 42 CFR 438.114, which relates to emergency and post-stabilization services, the Contractor may not limit what constitutes an emergency on the basis of lists of diagnoses or symptoms. The Contractor may not deny payment for treatment obtained when a member had an emergency medical condition, even if the outcomes, in the absence of immediate medical attention, would not have been those specified in the definition of emergency medical condition. The Contractor may not deny or pay less than the allowed amount for the CPT code on the claim without offering the provider the opportunity for a medical record review. The Contractor shall conduct a prudent layperson review to determine whether an emergency medical condition exists; the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field.

The Contractor is prohibited from refusing to cover emergency services if the emergency room provider, hospital or fiscal agent does not notify the member's PMP or the Contractor of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. The member who has an emergency is not liable for the payment of subsequent screening and treatment that may be needed to diagnose or stabilize the specific condition. 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 Contractor may not challenge the determination.

The Contractor shall comply with policies and procedures set forth the IHCP Provider Bulletin regarding Emergency Room Services Coverage dated May 21, 2009 (BT200913) and January 30, 2020 (BT202009), and any updates thereto.

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

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

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

If a prudent layperson review determines the service was not an emergency, the Contractor shall reimburse for physician services billed on a CMS-1500 claim, in accordance with the IHCP Provider Bulletin. The Contractor shall reimburse for facility charges billed on a UB-04 in accordance with the IHCP Provider Bulletin, if a prudent layperson review determines the service was not an emergency.

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

- A mechanism in place for a plan provider or Contractor representative to respond within one (1) hour to all emergency room providers twenty four (24) hours-a-day, seven (7) days-a-week. The Contractor will be financially responsible for the post-stabilization services if the Contractor fails to respond to a call from an emergency room provider within one hour.

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

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

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

- A mechanism, 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. The Contractor must at a minimum allow a provider to submit medical records for a prudent layperson review within 120 days of a claim's adjudication.

3.3.1 Emergency Room Services Copayment

A copayment will apply to non-Emergency use of an Emergency room by Hoosier Care Connect members. Other than Hoosier Care Connect members exempt from copayments as described in Section 12.3, all Hoosier Care Connect members will be subject to a copayment for all non-emergent use of hospital Emergency department services. Providers will collect the copayment from members. The Contractor shall include copayment information on the member's ID card that directs the provider to call the MCE for specific copayment amount due.

All members must receive an appropriate medical screening examination under section 1867 of the Emergency Medical Treatment and Active Labor Act. The copayment must be waived or returned if the member is found to have an Emergency condition, as defined in section 1867(e)(I)(A) of the Emergency Medical

Treatment and Active Labor Act, or if the person is admitted to the hospital within twenty-four (24) hours of the original visit.

In addition, the member copayment must be waived for any member who contacts the Contractor's 24-hour Nurse Call line prior to utilizing a hospital Emergency department to obtain advice on their medical conditions and the appropriate setting to receive care. The Contractor shall develop a process by which a member may contact the Contractor's 24-hour Nurse Call line to obtain a copayment waiver prior to utilizing a hospital Emergency department. If a member contacts the Nurse Call line prior to seeking Emergency care, the member will not be subject to the prudent layperson review to determine whether an Emergency medical condition exists for purposes of applying the copayment. The Contractor must have processes in place to communicate Emergency department copayment waivers on a prospective basis. In addition, the Contractor shall track and monitor whether members who contacted the 24-Hour Nurse Call line for purposes of copayment waiver were advised to seek Emergency services.

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

- The hospital may require payment of the copayment before the service can be provided;
- The hospital provides the name and location of an alternate non-Emergency services provider that is available and accessible at the time the call is made to the Nurse Line;
- An alternate provider can provide the services without the imposition of the copayment; and
- The hospital provides a referral to coordinate scheduling of this treatment.

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

3.3.2 Post-Stabilization Services

In accordance with 42 CFR 438.114(e) and IC 12-15-12-17, the Contractor must cover post-stabilization services. Post-stabilization services are covered services related to an Emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, to improve or resolve the member's condition. The requirements at 42 CFR 422.113(c) are applied to the Contractor. The Contractor is financially responsible for post-stabilization services obtained within or outside the network that are pre-approved by a plan provider or Contractor representative. The Contractor is also financially responsible for post-stabilization services that are not pre-approved but administered to a member to maintain the stabilized condition within one (1) hour of the request to the Contractor for pre-approval of further post-stabilization services. The Contractor must also reimburse for post-stabilization services when (i) the Contractor does not respond within one (1) hour to a request for pre-approval, (ii) the Contractor cannot be contacted or (iii) the Contractor and treating physician cannot reach an agreement concerning the members' care and a Contractor physician is not available for

consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with the care of the patient until a plan physician is reached or one of the following conditions is met:

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

3.4 Inpatient Services

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.

3.5 Care Conference Coverage

As described in further detail in Section 5.3.2, the Contractor shall engage the member's provider in care management through semi-annual care conferences. The Contractor shall reimburse the provider for participation in these care conferences. Services must be billed using Healthcare Common Procedure Coding System (HCPCS) 99211 SC – "office or other outpatient visit for the evaluation and management of an established patient." Contractors who elect not to utilize a primary medical provider (PMP) model, as described in Section 6.2.3, shall propose to FSSA for review and approval their proposed process for identifying what provider(s) will be engaged in the care conference process and what provider(s) will be eligible for reimbursement for the care conference.

3.6 Medication Therapy Management Services

The Contractor shall cover Medication Therapy Management (MTM) services, in accordance with this Section 3.6 which outlines goals, general requirements, target profile and reporting requirements (hereinafter, "guidelines").

3.6.1 Goals of the MTM Program

The goals listed below must remain at the forefront of the program processes implemented by the Contractor on behalf of Hoosier Care Connect members who are identified as high risk due to a combination of chronic disease state and multiple unique prescribed medications. The MTM program implemented must:

- Be patient focused;
- Improve medication use;
- Reduce risk of adverse events; and
- Improve adherence.

3.6.2 General Requirements

The general requirements are based on the CMS Medicare Part D MTM program requirements. While members may refuse to participate in the MTM program, the MTM activities which do not require the member's direct involvement shall continue to be performed by the Contractor. The Contractor shall continue to work with members who do not participate in, or cooperate with, the program. A significant part of MTM involves reviewing members' medication profiles looking for drug-drug interactions, drug-disease interactions, adverse reactions, drugs added to counteract side effects of other drugs, or drugs added that have redundant mechanisms of action and thereby increase the risk of toxicity. All of the aforementioned involve interventions with the prescriber and do not necessarily require member interaction. The Contractor is expected to retain metrics for members with whom the Contractor attempts to engage but refuse to participate or cooperate. The Contractor shall continue to attempt to involve those members and shall attempt to engage non-participating members, at minimum, on an annual basis.

The MTM program must:

- Provide interventions (e.g., Comprehensive Medication Review, Targeted Medication Review, review concerns members have about their medications, make recommendations to providers and members about medications) to be performed by registered pharmacists or other licensed medical professionals such as nurses, nurse practitioners, prescribers and other physicians.

- During the first four (4) months after Contract initiation, as members transition to Hoosier Care Connect, the Contractor must engage targeted members within one hundred eighty (180) days. Following this four (4) month period, the Contractor must engage new members targeted for MTM within sixty (60) days.

- Continue working with members who do not participate in, or cooperate with, the program. A significant part of MTM involves reviewing members' medication profiles looking for drug-drug interactions, drug disease interactions, adverse reactions, and drugs added to counteract side effects of other drugs. All of the aforementioned involve interventions with the prescriber and do not necessarily require member interaction.

- Interact with engaged members, following the initial MTM service, on a frequency as determined by the Contractor, based on member need, but not less than once per year.

- Include members with the following targeted conditions:

    - Alzheimer's Disease and other Dementias

    - Chronic Heart Failure (CHF)

    - Diabetes

    - Dyslipidemia

    - End-Stage Renal Disease (ESRD)

    - Hypertension

    - Respiratory Disease (i.e. Asthma, COPD, CF, etc.)

- Bone Disease (i.e. Arthritis, Osteoporosis, Osteoarthritis, Rheumatoid Arthritis)
- Mental Health Disorders (i.e. Depression, Psychosis, Schizophrenia, Bipolar Disorder, etc.)
- Neuromuscular Disorders (i.e. Multiple Sclerosis, Parkinson's Disease)
- Viral Disease (i.e. Hepatitis C, HIV, AIDS)

In performing MTM functions, the Contractor must demonstrate a thorough understanding of the federal regulations and guidelines which direct the monitoring, oversight, intervention and reporting of psychotropic drug utilization in children and adolescents. Further, in performing MTM functions the Contractor must collaborate and cooperate with the prescriber interventions made as a result of the Indiana Psychotropic Medication Initiative.

3.6.2.1 Comprehensive Medication Review (CMR)

The Contractor must offer a minimum level of MTM services to each member enrolled in the program that includes interventions with members and prescribers.

CMR must include:

- Medication action plan;
- Personal medication list;
- Summary of recommendations; and
- Medication refill reminders.

3.6.3 Target Members

The MCE MTM program is expected to target members.

Targeted members must meet all of the following criteria:

- Have three or more (3+) of the targeted conditions in Section 3.6.2 based on drug claims; and
- Eight or more (8+) chronic drug claims within the past 12 months.

3.6.4 Reporting

Reporting is a critical factor in determining effectiveness of individual MTM programs as well as the MTM program for all Indiana Medicaid members. OMPP retains the authority to request reporting and metrics, as appropriate, to determine effectiveness of individual programs. Minimum requirements for reporting include semi-annual reporting. Reporting requirements include, but are not limited to the following:

- Number of members enrolled;
- Average number of disease states;

- Top 5 (five) disease states engaged;
- Measure of return on investment (ROI);
- Change in adherence rate for enrolled members; and
- Measure of member/provider satisfaction.

3.7 Diabetes Supplies Coverage

The Contractor shall cover diabetes supplies in alignment with FSSA's Preferred Diabetes Supply List (PDSL). The Contractor shall configure its claims payment system to approve the diabetes supplies of FSSA's contracted vendors preferred blood glucose monitors and diabetic test strips for all IHCP enrollees. The Contractor shall require prior authorization for all of FSSA's non-preferred blood glucose monitors and diabetic test strips.

3.8 Drug Coverage

Prescription drugs, certain over-the-counter drugs, and pharmacy supplements are benefits under the Hoosier Care Connect program to be covered by the Contractor. The Contractor agrees to abide by 42 CFR 437-438.3(s), the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) and P.L. 115-271, "SUPPORT" Act. If directed as such by FSSA, the Contractor shall utilize a common or unified PDL/PA criteria, including discontinuation of commercial discount and commercial rebates agreements with pharmaceutical manufacturers for IHCP member pharmacy benefits, or consolidation of the pharmacy benefit under the FFS program.

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

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

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

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

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

3.8.1 Drug Rebates

The Contractor shall ensure compliance with the requirements under Section 1927 of the Social Security Act. In accordance with the Affordable Care Act, manufacturers that participate in the Medicaid drug rebate program are required to pay rebates for drugs dispensed to individuals enrolled with a Medicaid Managed Care Entity. To facilitate collection of these rebates, FSSA must include utilization data of Hoosier Care Connect

contractors when generating quarterly drug rebate invoices to manufacturers as well as reporting quarterly utilization statistics to the Centers for Medicare and Medicaid Services (CMS). The Contractor shall provide reports to the State to support rebate collection. This reporting shall include physician-administered drugs. The State intends to use and share the Contractor paid amount information on the State's pharmacy claims extracts for rebate purposes.

The Contractor shall provide this reporting to the State in the manner and timeframe prescribed by FSSA, including, but not limited to, through the submission of complete and accurate pharmacy encounter data and a rebate file to the State or its designee. An example of a rebate file is provided in the Bidders' Library; this file layout is provided as an example only and is subject to change. Throughout the course of the Contract, FSSA may update the file layout to support rebate collection. FSSA shall make its best effort to provide the Contractor sixty (60) days advanced notice of the change and the Contractor shall be required to comply with the change in the timeframe designated by the State. The Contractor shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of paid amounts. Failure to comply with the drug rebate reporting requirements established by FSSA will subject the Contractor to the remedies outlined in Contract Exhibit 2 Contract Compliance and Pay for Outcomes. Requirements for pharmacy encounter claims are outlined in Section 8.6. Additionally, the Contractor shall assist FSSA or the State's PBM contractor in resolving drug rebate disputes with a manufacturer, at Contractor's expense.

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

3.8.2 Preferred Drug List Requirements

The Contractor shall maintain a preferred drug list (PDL). In accordance with IC 12-15-35-46, State approval of the PDL shall be required prior to Contractor implementation. The Contractor shall submit the proposed PDL to FSSA at least thirty-five (35) calendar days before the intended PDL implementation date. The FSSA shall submit the PDL to the DUR Board for review and recommendation. The Contractor shall be accessible to the DUR Board to respond to any questions regarding the PDL. The DUR Board will provide a recommendation regarding approval of the PDL in accordance with the terms of IC 12-15-35-46. FSSA will approve, disapprove or modify the formulary based on the DUR Board's recommendation. The Contractor shall comply with the decision within sixty (60) days after receiving notice of the decision.

The Contractor shall utilize a Pharmacy and Therapeutics Committee which shall meet regularly to make recommendations for changes to the PDL. In accordance with IC 12-15-35-47, prior to removing one (1) or more drugs from the PDL or placing new restrictions on one (1) or more drugs, the Contractor shall submit the proposed change to FSSA which shall forward the proposal to the DUR Board. Such changes shall be submitted at least thirty-five (35) calendar days in advance of the proposed change. The Contractor shall also meet with FSSA staff and/or the DUR Board, as directed by FSSA, to answer questions about the clinical rationale for the proposed change. The Contractor is not required to seek approval from the State in order to add a drug to the PDL; however, the Contractor shall notify FSSA of any addition to the PDL within thirty (30) days after making the addition.

In accordance with CMS-2390-F, the Contractor shall demonstrate prescription drug coverage consistent with the amount, duration, and scope of the fee-for-service program. The Contractor shall engage with the State to develop universal medically necessary prior authorization criteria for IHCP. The Contractor shall implement the universal IHCP criteria into their program and may not utilize more restrictive criteria.

The Contractor shall maintain an Over-the-Counter (OTC) Drug Formulary and Pharmacy Supplements Formulary which contains, at a minimum, the same items included in the FFS OTC Drug Formulary and Pharmacy Supplements Formulary and as updated by the DUR Board. Any additions to the Contractor OTC Drug Formulary are required to only be from participating rebating labelers.

The PDL shall be made readily available to providers in the Contractor's network and to members by linking to the Pharmacy Services page on https://www.in.gov/medicaid/. The PDL shall be formatted in a similar manner to the FFS PDL, listing both preferred and nonpreferred drugs, as well as applicable edits. The PDL shall be updated and posted on or before the intended PDL implementation date to reflect all changes in the status of a drug or addition of new drugs. The Contractor shall also support e-Prescribing technologies to communicate the PDL to prescribers through electronic medical records (EMRs) and e-Prescribing applications. Refer to 3.8.5 for additional requirements on e-Prescribing.

Notwithstanding the foregoing, the Contractor may opt to utilize the State's PDL and to contract with the State's PBM contractor for pharmacy claims processing. If the Contractor takes this approach, a Contractor Pharmacy and Therapeutics Committee shall not be required and the Contractor shall be permitted to utilize the work of the Therapeutics Committee and DUR Board in maintaining the State's PDL.

Also, prescriptions obtained by a Hoosier Care Connect member that are not otherwise exempt on the basis outlined in Section 12.2, are subject to the copayment amounts set forth in the same Section. Copayments assessed to the Hoosier Care Connect member at the point of sale may not exceed the total cost of the drug.

3.8.3 DUR Board and MHQAC Reporting Requirements

The DUR Board shall review the prescription drug program of the contractor at least one (1) time per year, doing so in compliance with IC 12-15-35-48.

In addition to the DUR Board approval, the Contractor must also seek the advice of the Mental Health Quality Advisory Committee (MHQAC), as required in IC 12-15-35.5, prior to implementing a restriction on a mental health drug described in IC 12-15-35.5-3(b). The Contractor shall comply with any additional reporting requests required for submission to the DUR Board and MHQAC.

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

The Contractor shall comply with the requirements of IC 12-15-35.5-3 in establishing prior authorization requirements for mental health drugs.

3.8.4 Dispensing and Monitoring Requirements

The Contractor shall administer pharmacy benefits in accordance with all applicable state and federal laws and regulations. For any drugs which require prior authorization, the

Contractor shall provide a response by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization. Additionally, the Contractor shall provide for the dispensing of at least a seventy-two (72) hour Emergency supply of a covered outpatient prescription drug, as required under 42 U.S.C 1396r-8(d)(5)(B), without prior authorization.

The Contractor may require prior authorization requirements, such as general member information, a justification of need for drug related to the medical needs of the member and a planned course of treatment, if applicable, as related to the quantity of drug provided and duration of treatment. The Contractor will be required to have a process in place to allow member access to medically necessary non-preferred (non-formulary) drugs. 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 Contractor's criteria must be consistent with the amount, duration and scope of that criteria and may not be more stringent.

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

3.8.5 E-Prescribing

The Contractor shall support e-Prescribing services. Much of the e-Prescribing activity is supported by prescribing providers through web and office-based applications or certified electronic health record (EHR) systems to communicate with the pharmacies. When EHR systems are used, the Contractor shall supply the EHR systems with information about member eligibility, patient history and drug formulary.

3.8.6 Carve-Out of Select Drugs

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

3.8.7 340B

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

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

At any given point in time, the State may elect to require the use of 340B-related modifiers on claims. In such an instance, the Contractor shall require its providers to use the selected modifiers on their claims, and the Contractor will be required to deny payment for claims that do not contain necessary modifiers. The State will work with the Contractor in determining a mutually agreeable workplan and time line for implementation of use of modifiers by the Contractor's providers.

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

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

3.8.8 Pharmacy Continuity of Care

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

3.8.9 SUPPORT Act Compliance

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

1. Safety edits and claims review automated process for the State-approved maximum daily morphine limitation
2. Safety edits and claims review automated process for the State-approved maximum daily morphine equivalent for treatment of chronic pain
3. Claims review automated process that monitors when a client is concurrently prescribed opioids and benzodiazepines, or is concurrently prescribed opioids and antipsychotics
4. Program to monitor and manage the appropriate use of antipsychotic medications by Medicaid children
5. Process that identifies potential fraud or abuse of controlled substances by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies

3.9 Smoking Cessation and Tobacco Dependence Treatment

The Contractor must cover, at minimum, Smoking Cessation and Tobacco Dependence Treatment as set forth in 405 IAC 5-37. Drug coverage and criteria shall be consistent with the fee-for-service program (refer to 3.8 Drug Coverage), including counseling and all covered outpatient drugs indicated for Smoking Cessation and Tobacco Dependence Treatment. Providers may prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment. The Contractor shall provide each member identified as using tobacco or tobacco related products, information regarding the availability of tobacco cessation services provided through the Indiana Quitline. The Contractor shall create and implement a physician incentive program specific to tobacco dependence counseling.

3.10 Behavioral Health Services

Behavioral health services, with the exception of MRO and 1915(i) services as described in Sections 3.13.1 and 3.13.2, are a covered benefit under the Hoosier Care Connect program that the Contractor is responsible for managing and reimbursing. The Contractor shall provide timely access to behavioral health screening, assessment, referral and treatment services, including outpatient services as well as inpatient psychiatric hospital services, inpatient drug and alcohol detoxification and inpatient drug and alcohol rehabilitation, with the exception of treatment rendered in a State Hospital as described in Section 3.14.2, and residential treatment services for opioid use disorder (OUD) and substance use disorder (SUD). As described in Section 3.17, the Contractor is encouraged to develop and purchase enhanced services which can provide services in a less restrictive setting and/or which would result in improved outcomes for members.

In furnishing behavioral health benefits, the Contractor shall comply with the Mental Health Parity and Addiction 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 Contractor to Hoosier Care Connect members beyond those specified in Indiana's Medicaid state plan;

- Making the criteria and guidelines used to determine medical necessity for mental health or substance use disorder benefits available to any current or potential member, 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; and

- 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.

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

- Provide care that addresses the needs of Hoosier Care Connect 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 Contractor, behavioral health and non-behavioral health care providers;

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

- Address the unique behavioral health and developmental needs of wards, foster children and former foster children, including, but not limited to (i) frequent psychiatric inpatient utilization; (ii) psychotropic medication use; and (iii) assisting children as they age out of the foster care system.

The Contractor will provide behavioral health services through hospitals, offices, clinics, in homes, and other locations, as permitted under state and federal law. A full continuum of services, including crisis services, as indicated by the behavioral health care needs of members, shall be available to members. Behavioral health services codes billed in a primary care setting must be reviewed for medical necessity, and, if appropriate, shall be paid by the Contractor. As described in Sections 3.13.1 and 3.13.2, MRO and 1915(i) services are carved-out from the Contract. The State shall provide data to the Contractor on members eligible for MRO and 1915(i) services. The Contractor shall utilize this data to ensure coordination with these carved-out services. The Contractor shall coordinate with the CMHC case managers in the delivery of MRO and 1915(i) services.

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

3.10.1 Identification of Behavioral Health Care Needs

The initial screening and comprehensive health assessment utilized by the Contractor and described in Section 5.1 shall screen all new members for behavioral health needs and conditions. Additionally, the Contractor shall develop mechanisms to facilitate the identification by physical health providers of members in need of behavioral health services. The Contractor shall train all contracted medical providers in identifying and treating members with behavioral health disorders and co-existing mental health and substance abuse disorders. Training shall also include when and how to refer members for behavioral health treatment.

3.10.2 Behavioral Health Care Coordination

The Contractor must ensure the coordination of physical and behavioral health care among all providers treating the member. The Contractor must coordinate services for individuals with multiple diagnoses of mental illness, substance abuse and physical illness. The Contractor must have policies and procedures to facilitate the reciprocal exchange of social, physical and behavioral health information between physical and behavioral health providers treating the member. Given the State's commitment to increasing the levels of Primary Care Behavioral Health Integration across its care infrastructure, the Contractor shall develop strategies that will allow for the expansion of care coordination, data reporting, and outcomes measurement.

The Contractor must contractually mandate that its behavioral health care network

providers notify a member's Contractor within five (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 Contractor and to the member's physician is permissible under 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. Contractors must contractually require every network provider to ask and encourage members to sign a consent that permits release of substance abuse treatment information to the Contractor and to the member's physical or behavioral health providers, if applicable.

The Contractor will have developed and implemented mechanisms to ensure coordination among member's providers by the Contract Start Date. With appropriate consent, the Contractor shall notify behavioral health providers and medical providers when a member is hospitalized or receives Emergency treatment for behavioral health issues, including substance abuse. Refer to Section 3.12 for notification requirements for non-behavioral health admissions and Emergency services. This notice must be provided within seventy-two (72) hours of the hospital inpatient admission or Emergency treatment. The Contractor shall maintain strategies to receive hospital notification of inpatient admissions to facilitate meeting this requirement, for example, through the use of incentive programs.

The Contractor must, on at least a quarterly basis, send a health profile to the member's respective primary medical and behavioral health provider. If the Contractor does not utilize a PMP model as described in Section 6.2.3, mechanisms must be in place to identify the appropriate physical and behavioral health provider responsible for the member's care to whom the health profile will be sent. The health profile provides, in a concise format, the physical and behavioral health treatment received by the member during the previous reporting period. Information about substance abuse treatment and HIV/AIDS should only be released if member consent has been obtained. The Contractor shall provide a template of the proposed health profile to be utilized for FSSA review and approval. The State reserves the right to require the Contractor to utilize reporting capabilities through the Medicaid Management Information System (MMIS) to implement the health profile requirement. The State shall provide advanced notice to the Contractor if this option will be implemented.

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

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

Contractors 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 Contractor must develop and maintain additional mechanisms for facilitating

communication between behavioral health and physical health providers to ensure the provision of integrated member care. The Contractor shall maintain mechanisms for ensuring social, physical, and behavioral health integration and information sharing. Incentive programs, case managers, behavioral health profiles, etc. are potential mechanisms to ensure care coordination, and the reciprocal exchange of health information between physical and behavioral health providers.

The Contractor shall evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes. Documentation of integration policies and procedures and outcomes data shall be made available to FSSA upon request, and at minimum on a semi-annual basis.

Additionally, the State is exploring implementation of new initiatives for behavioral and physical health integration for Indiana Medicaid members. The Contractor shall participate in the planning and execution of State-driven integration activities at the direction of FSSA. These new initiatives will result in a higher level of integration of services. The Contractor shall provide enhanced care coordination as may be required as a result of these initiatives.

3.10.3 Behavioral Health Continuity of Care

The Contractor must monitor the care of a member receiving behavioral health services who is new to the Contractor or who is transitioning to another managed care entity (MCE) or other treatment provider, to ensure that medical records, treatment plans and other pertinent medical information follows the transitioning member. The Contractor 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 Contractor and receiving MCE must coordinate information regarding prior authorized services for members in transition in accordance with Section 3.15.

The Contractor must ensure there is adequate discharge planning for members hospitalized for a behavioral health condition. Members must not be discharged to homelessness. The Contractor shall coordinate with hospital discharge planners and CMHC case managers (if the member is receiving case management through a CMHC). The Contractor must require, through provider agreement provisions, that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The Contractor shall make every effort to ensure treatment is provided within seven (7) calendar days from the date of the member's discharge. If a member misses an outpatient follow-up or continuing treatment, the Contractor must ensure that a behavioral health care provider or the Contractor's behavioral health case manager contacts that member within three (3) business days of the missed appointment.

The State is exploring implementation of new initiatives for behavioral health integration for Indiana Medicaid members that is expected to result in a higher level of integration of services. The Contractor shall provide enhanced care coordination at the direction of the State as a result of these initiatives.

3.10.4 Institution for Mental Disease (IMD)

Pending CMS approval, FSSA reserves the right to alter the coverage and length of stay restrictions in this section. The Contractor will cover short term stays in an Institution for

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

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

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

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

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

Lists of qualified IMD providers under both §1115 waivers will be provided to the Contractor. The Contractor may not require or create incentives for the member to receive services in an IMD versus a setting covered under the State Plan.

In accordance with 42 CFR 435.1010, an IMD is generally defined as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases." This may include a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services. The Contractor will be responsible for reviewing and understanding all specific State criteria to distinguish qualifying IMDs under both SMI and SUD §1115 demonstrations as well as all related State guidance.

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

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

3.11 Dental Services

Dental services are critical to ensuring the overall health of IHCP members. As such, dental services are a covered benefit under the Hoosier Care Connect program per Exhibit 3 Program Description and Covered Benefits that the Contractor is responsible for managing and reimbursing. The Contractor will develop a comprehensive oral health strategy, in consultation with dental providers, that ensures appropriate utilization of this benefit by members consistent with dental standards of care.

3.12 Inpatient Hospitalization Notification

With appropriate consent, the Contractor shall notify a member's physician when a member is hospitalized or receives Emergency treatment. This notice must be provided within five (5) calendar days of the hospital inpatient admission or Emergency treatment. The Contractor shall maintain strategies to receive hospital notification of inpatient admissions to facilitate meeting this requirement, for example, through the use of incentive programs.

3.13 Carved-Out Services

The services described in this section are excluded from the Contractor's capitation rate; these are referred to as "carved-out" services. The State's fiscal agent pays claims for carved-out services on a fee-for-service basis for the Contractor's members. While these services are not the financial responsibility of the Contractor, the Contractor shall ensure coordination of all Medicaid covered services and implement strategies to prevent duplication and fragmentation of care across the healthcare delivery system, including as may result from new initiatives. The Contractor shall maintain strategies to ensure coordination for carved-out services.

3.13.1 Medicaid Rehabilitation Option (MRO) Services

MRO services are intensive community-based behavioral health services delivered exclusively by CMHCs. Medicaid members requiring MRO services are assigned a service package based on qualifying diagnosis and level of need, as determined by an individualized assessment conducted by CMHCs. The Contractor is not responsible for claims reimbursement for MRO services but is responsible for ensuring coordination of care for members receiving MRO services. The State shall provide data to the Contractor identifying members receiving MRO services.

A complete listing of carved-out MRO services is provided in Contract Exhibit 3 Program Description and Covered Benefits. Further information on the behavioral health services which are the financial responsibility of the Contractor are described in Section 3.10.

3.13.2 1915(i) State Plan Home and Community-Based Services

The State has three (3) 1915(i) State Plan Home and Community-Based services programs: Behavioral and Primary Healthcare Coordination (BPHC), Adult Mental Health Habilitation (AMHH) and Child Mental Health Wraparound (CMHW). These services are carved-out of the Contractor's financial responsibility. The Contractor shall coordinate with 1915(i) service providers to prevent duplication and fragmentation of services. A listing of carved-out 1915(i) services is provided in Contract Exhibit 3 Program Description and Covered Benefits.

3.13.3 Individualized Family Services Plan (IFSP)

IFSP services provided under the FSSA First Steps program are carved-out from the Contractor's financial responsibility.

3.13.4 Individualized Education Plan (IEP) Services

IEP services provided by a school are carved-out from the Contractor's responsibility. The Contractor shall communicate and coordinate with the school to ensure continuity of care and avoid duplication of services.

3.13.5 Carved Out Drug Classes

See Section 3.8.6.

3.14 Excluded Services

The Hoosier Care Connect program excludes some benefits from coverage under managed care. These excluded benefits are available under traditional Medicaid. A Contractor's members who are, or will be, receiving excluded services shall be disenrolled from Hoosier Care Connect and enrolled in traditional Medicaid. The Contractor is responsible for the member's care until the member is disenrolled by FSSA unless otherwise stated.

3.14.1 Long-Term Institutional Care

Hoosier Care Connect members requiring long-term care in a nursing facility shall be disenrolled from the Contractor's Hoosier Care Connect product and enrolled in traditional Medicaid. Before the nursing facility can be reimbursed fee-for-service 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 the MMIS and disenroll the member from Hoosier Care Connect. The Contractor must coordinate care for its members that are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR, as described in the IHCP Provider Manual. The Contractor is responsible for payment for up to sixty (60) calendar days for its members placed in a long-term care facility while the level of care determination is pending.

The Contractor may obtain services for its members in a nursing facility setting on a short-term basis, defined as fewer than thirty (30) calendar days. This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. The Contractor may negotiate rates for reimbursing the nursing facilities for these short-term stays. All over-the-counter, legend, and nonlegend drugs, including physician-administered drugs are not considered allowable costs and should not be included in the per diem rate. All drugs must be reimbursable through the pharmacy benefit but may be subject to prior authorization and safety edits that are no more restrictive than Fee-for-Service. If a member admitted to a nursing facility for a short-term stay remains in the nursing facility for more than thirty (30) days, the Contractor shall notify the State or its designee, in the timeframe and format required by FSSA. The Contractor may request disenrollment of a member in these cases, which shall be determined in FSSA's sole discretion.

3.14.2 Psychiatric Treatment in a State Hospital

Hoosier Care Connect members who are admitted to a State Hospital for psychiatric treatment shall be disenrolled from the Contractor.

3.14.3 Psychiatric Residential Treatment Facility (PRTF) Services

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

3.14.4 Intermediate Care Facilities for Individuals with Intellectual Disabilities

Hoosier Care Connect members who are admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) shall be disenrolled from the Contractor and enrolled in traditional Medicaid. Before the stay can be reimbursed by the IHCP, the level of care must be approved by the State. The Contractor must coordinate care for its members that are transitioning into an ICF/IID by working with the facility. The Contractor is responsible for payment for up to sixty (60) calendar days for its members placed in an ICF/IID while the level of care determination is pending.

3.14.5 Home and Community-Based Services (HCBS)

HCBS members are excluded from the Hoosier Care Connect program. Individuals who have been approved for these waivers will be disenrolled from managed care. The Contractor shall coordinate care for its members that are transitioning into the waiver.

3.15 Continuity of Care

The State is committed to providing continuity of care for members as they transition between various IHCP programs and the Contractor's enrollment. The Contractor shall implement mechanisms to ensure the continuity of care and coordination of medically necessary health care services for members transitioning in and out of the Hoosier Care Connect program and the Contractor's enrollment. The Contractor shall maintain strategies for ensuring continuity of care during all transitions. Possible transitions between programs include, but are not limited to:

- Initial enrollment with the Contractor;
- Transitions between Hoosier Care Connect Contractors during the first ninety (90) days of enrollment or at any time for cause;
- Transition to Medicare;
- Transition of Hoosier Care Connect wards and foster children when placement changes, they enter the foster care system or age out of foster care; and
- Transition to traditional Medicaid due to receipt of an excluded service as described in Section 3.14.

The Contractor shall be required to honor outstanding authorizations for a minimum of ninety (90) calendar days when a member transitions to the Contractor from another source of coverage.

Additionally, the Contractor shall maintain an individual's case management stratification until a new assessment is completed when a member transitions from another Hoosier Care

Connect Contractor at any time during the Contract term. More information on the assessment and stratification requirements are found in Section 5.0.

The Contractor must establish and maintain policies and procedures for identifying outstanding prior authorization decisions and case management assignment at the time of the member's enrollment in their plan. Additionally, when a member transitions to another source of coverage, the Contractor shall be responsible for providing the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as disease management, case management or care management notes. This process shall be overseen by the Transition Coordinator described in Section 2.10.3.

The Contractor will be responsible for all care coordination after the member has disenrolled from the Contractor whenever the member disenrollment occurs during an inpatient stay. In these cases, the Contractor maintains financial responsibility for all charges incurred up to the date of disenrollment, including the hospital diagnosis related group (DRG) payment. The Contractor must coordinate discharge with the member's new MCE.

3.16 Out-of-Network Services

With the exception of the self-referral services described in Section 3.1, and the requirement to allow continuity of care described in Section 3.15, once the Contractor has met the network adequacy standards described in Section 6.0, the Contractor may require members to seek covered services from in-network providers. However, in accordance with 42 CFR 438.206(b)(4), if the Contractor is unable to provide the necessary covered services in-network to a member within sixty (60) miles of the member's residence, the Contractor shall provide such services out-of-network, for as long as the Contractor is unable to provide them in-network. Per 42 CFR 438.206(b)(5), the cost to a member for out-of-network services must be no greater than if the services were received in-network.

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

The Contractor shall reimburse any out-of-network provider's claim for authorized services at a negotiated rate, or in the absence of a negotiated rate, an amount equal to ninety-eight percent (98%) of the Medicaid fee-for-service rate.

The Contractor shall make nurse practitioner services available to members to supplement MD and DO services. Members must be allowed to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the member's service areas within the Contractor's network. The Contractor must inform the member that nurse practitioner services are available.

The Contractor may not require an out-of-network provider to acquire a Contractor assigned provider number for reimbursement. A National Provider Identifier (NPI) number shall be sufficient for out-of-network provider reimbursement.

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

The Contractor 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 Care Connect

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 does not meet the requirements of HEA 305, 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. A list of eligible hospitals is provided to the Contractor.

The Contractor 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), or the outlier payment (if applicable).
- 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.

3.17 Enhanced Services

The State encourages the Contractor to cover programs that enhance the general health and well-being of its members, including programs that address preventive health, chronic conditions, risk factors or personal responsibility. These enhanced programs and services are above and beyond those covered in the Hoosier Care Connect program. The Contractor shall provide information on enhanced services to be offered. The Contractor must obtain FSSA approval for any proposed enhanced services and must comply with all member incentives guidelines as set forth in Section 7.2.2 and state and federal law regarding inducements. Enhanced services associated with a provider claim must be appropriately flagged as such by the health plan to ensure that it is appropriately excluded during the capitation rate setting process

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

- Incentives for obtaining preventive services;
- Enhanced transportation arrangements such as transportation to obtain pharmacy or attend member education workshops;
- Medical equipment or devices not already covered under the Hoosier Care Connect 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.

3.18 Opioid Treatment Program (OTP)

The Contractor shall provide coverage for the Opioid Treatment Program (OTP) for members receiving services at OTPs. A daily opioid treatment program includes administration and coverage of methadone or buprenorphine, routine drug testing, group therapy, individual therapy, pharmacological management, HIV testing, Hepatitis A, B, and C testing, pregnancy tests, Tuberculosis testing, Syphilis testing, follow-up examinations, case management and one evaluation and management office visit every 90 days for the management of patient activities identified in the individualized treatment plan that assist in patient goal attainment, including referrals to other service providers and linking patients to recovery support groups. OTP coverage will include those members as defined by OMPP and approved by CMS. The MCE will be responsible for OTP services provided by the provider type Addictions Provider and the provider specialty OTP as defined in the IHCP Provider Enrollment Type and Specialty Matrix.

Coverage of OTP services will be restricted as follows:

- Individuals aged 18 and older seeking OTP services must meet the following medical necessity criteria:
    - Must be addicted to an opioid drug
    - Must have been addicted for at least one year before admission to the OTP
    - Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria
- Individuals under the age of 18 seeking OTP services must meet the following medical necessity criteria:
    - Must be addicted to an opioid drug
    - Must have two documented unsuccessful attempts at short-term withdrawal management or drug-free addiction treatment within a 12-month period preceding admission
    - Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the ASAM Patient Placement Criteria
- The following individuals are exempt from the one-year addiction requirement:
    - Members released from a penal institution – If the individual seeks OTP services within six months of release
    - Pregnant women
    - Previously treated individuals – If the individual seeks OTP services within two years after treatment discharge

Prior authorization (PA) is not required for OTP services. However, providers must maintain documentation demonstrating medical necessity, that the coverage criteria are met, as well as the individual's length of treatment, in the member's records.

3.19 Non-Emergency Medical Transportation Services

Non-emergency medical transportation (NEMT) services are a covered benefit under the Hoosier Care Connect program per Exhibit 3 Program Description and Covered Benefits that the Contractor is responsible for managing and reimbursing. NEMT services are intended for members who have no other means of transportation available to them. Per Section 12.2 Hoosier Care Connect Member Copayments, members enrolled in Hoosier Care Connect are required to pay a $1-dollar ($1.00) copayment for one-way transportation services at the time services are rendered.

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

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

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

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

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

3.20 Residential Substance Use Disorder (SUD) Services

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

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

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

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

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

3.21 Hospice Services

Hospice services are covered under the Hoosier Care Connect Program. Hoosier Care Connect members receiving hospice services will remain enrolled with their MCE even while receiving inpatient (non-hospice) care. Examples of inpatient non-hospice care includes but are not limited to: rehabilitation facilities, skilled nursing facilities and hospital admissions.

For further information on Hospice services consult all applicable reference materials including, Indiana Medicaid Medical Policy Manual, the Hospice Module and the Prior Authorization Module, Managed Care Programs Policies and Procedures Manual.

4.0 Member Services

4.1 Marketing and Outreach

The Contractor is encouraged to market its plan to the general community. In accordance with 42 CFR 438.104, and the requirements outlined in Section 4.9, the Contractor must obtain State approval for all marketing materials at least thirty (30) calendar days prior to distribution. All marketing materials must be distributed to the Contractor's entire service area and shall comply with the information requirements delineated at 42 CFR 438.10. Such materials shall be in a manner and format that is easily understood and meet the general communication material requirements discussed further in Section 4.7.2. Marketing materials should include the requirements and benefits of the Contractor's health plan, as well as the Contractor's provider network.

The Contractor may market via digital, mail and mass media advertising such as digital media, radio, television and billboards. Community oriented marketing such as participation in community health fairs is encouraged. Tokens or gifts of nominal value may be distributed at such events to potential members, so long as the Contractor acts in compliance with all marketing provisions provided for in 42 CFR 438.104, and other federal and state regulations and guidance regarding inducements in the Medicaid program.

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

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

The Contractor cannot entice a potential member to join its health plan by offering any other type of insurance as a bonus for enrollment, and the Contractor must ensure that a potential member can make his or her own decision as to whether or not to enroll. Marketing materials and plans shall be designed to reach a broad distribution of potential members across age and gender categories. The Contractor must conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. The Contractor must provide information to potentially eligible individuals who live in

medically underserved rural areas of the State. Potential members may not be discriminated against on the basis of health status or need for health care services, or on any other basis inconsistent with state or federal law, including Section 1557 of the Affordable Care Act / 45 CFR 92.1.

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

The Contractor may submit promotional poster-sized wall graphics to FSSA for approval to be considered for use in the local FSSA Division of Family Resources (DFR) offices. The local DFR offices and enrollment centers may choose to display these promotional materials at their discretion. The Contractor may display these same promotional materials at community health fairs or other outreach locations. FSSA must pre-approve all promotional and informational brochures or flyers and all graphics prior to display or distribution. Refer to Section 4.9 for a description of the required approval process.

4.2 Member Enrollment and Contractor Selection

Hoosier Care Connect applicants shall have the opportunity to select an MCE at the time of Medicaid application. The State's Enrollment Broker will provide information and assistance with MCE selection to applicants.

In accordance with 42 CFR 438.10(e), the State must provide potential members with general information about the basic features of managed care and information specific to each MCE operating in the potential member's service area. At minimum, this information will include factors such as MCE service area, benefits covered, cost-sharing and network provider information. The State shall provide information on Hoosier Care Connect MCEs in a comparative chart-like format. Once available, the State also intends to include Contractor quality and performance indicators on materials distributed to facilitate MCE selection. The State reserves the right to develop a rating system advertising Contractor performance on areas such as consumer satisfaction, network access and quality improvement. To facilitate State development of these materials, the Contractor must comply with State, or its designee, requests for information needed to develop informational materials for potential members.

Members who do not select an MCE at the time of application, and Supplemental Security Income (SSI) recipients who are not required to submit a Medicaid application, shall receive information from the State or its designee describing the process to select an MCE. Individuals who do not select a Contractor within sixty (60) calendar days of the enrollment mailing will be auto-assigned to a Contractor in accordance with an auto-enrollment algorithm to be designed by the State. The State reserves the right to revise the timing and strategies employed to facilitate member selection. Additional information on the auto-assignment process can be found in Contract Exhibit 4 Responsibilities of the State.

4.3 Enrollment Discrimination

Per 42 CFR 438.3(d), the Contractor must accept individuals eligible for enrollment in the order in which they apply without restriction. The Contractor shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll in Hoosier Care Connect. Additionally, the Contractor shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. Further, the Contractor will not use any policy or practice that has the effect of discriminating in any such manner. Contractor shall also adhere to Section 1557 of the Affordable Care Act / 45 CFR 92.1.

4.4 Enrollment Packet

Within five (5) calendar days of a new member's full enrollment with the Contractor in accordance with Section 4.8, the Contractor shall send the new member a Welcome Packet based on the State's model enrollee handbook. All information in the Enrollment Packet shall meet the general information requirements set forth in Section 4.7.2 and shall be submitted for State review and approval prior to distribution in accordance with Section 4.9. The Enrollment Packet shall include, but not be limited to a welcome letter, member ID card, explanation of where to find information about the Contractor's provider network information and a member handbook. Such materials shall meet the requirements described in detail below. The Enrollment Packet shall also include information on completing a health screening, a process described in further detail in Section 5.1.

4.4.1 Provider Network Information

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

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

A printed copy of the provider directory must also be available to members and FSSA upon request. The Contractor must include the aforementioned provider network information, by county, on its member website. The information must be updated, at minimum, every two (2) weeks. Network provider information must be available to print from a remote user location.

4.4.2 Member Handbook

The member handbook may be offered in an electronic format as long as the Contractor complies with 42 CFR 438.10(c)(6). The member handbook must include the Contractor's contact information and Internet website address and describe the terms and nature of services offered by the Contractor, including the following information required under 42 CFR 438.10(f):

- Contractor's contact information (address, telephone number, TDD number, web site);
- Contractor's office hours and days, including the availability of a twenty-four (24) hour

Nurse Call Line;

- The amount, duration and scope of services available under the Contract in sufficient detail to ensure that participants are informed of the services to which they are entitled, including service authorization requirements;
- The procedures for obtaining benefits, including authorization requirements;
- Standards and expectations for receiving preventive health services;
- The extent to which, and how, after-hours and Emergency coverage are provided, as well as other information required under 42 CFR 438.10(f) related to Emergency services;
- The post-stabilization care services rules set forth in 42 CFR 422.113(c);
- Any applicable policies on referrals for specialty care and other benefits;
- Information on how to access non-emergency medical transportation, the limitation of NEMT as well as the member responsibilities for scheduling, using, and cancelling rides;
- Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out-of-network providers;
- Special benefit provisions (for example, limits or rejections of claims) that may apply to services obtained outside the Contractor's network;
- Procedures for obtaining out-of-network services;
- Grievance, appeal and fair hearing procedures as required at 42 CFR 438.10(g)(2)(xi), and described in Section 4.12, including the following:
    - The right to file grievances and appeals;
    - The requirements and timeframes for filing a grievance or appeal;
    - The availability of assistance in the filing process;
    - The toll-free numbers that the member can use to file a grievance or appeal by phone; and
    - The fact that, if requested by the member and under certain circumstances: 1) benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and 2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.
- For a State hearing:
    - The right to a hearing;
    - The method for obtaining a hearing; and

- The rules that govern representation at the hearing.

- Member rights and protections, as enumerated in 42 CFR 438.100 and as further detailed in Section 4.10 of this Scope of Work;

- Responsibilities of members;

- 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 of the Contractor to provide covered services;

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

  - Significant language or cultural barriers;

  - Corrective action levied against the Contractor by FSSA;

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

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

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

  - A service is not covered by the Contractor for moral or religious objections, as described in Section 7.3.2;

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

  - Lack of access to providers experienced in dealing with the member's healthcare needs;

  - The member's primary healthcare provider disenrolls from the member's current MCE and re-enrolls with another Hoosier Care Connect MCE; or

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

- The process for submitting disenrollment requests. This information must include the following:

- Members may change MCEs after the first ninety (90) calendar days of enrollment only when they have just cause;
- Members are required to exhaust the MCE's internal grievance and appeals process before requesting an MCE change for poor quality of care;
- Members may submit requests to change MCEs to the Enrollment Broker verbally or in writing, after exhausting the MCE's internal grievance and appeals process; and
- The MCE must provide the Enrollment Broker's contact information and explain that the member must contact the Enrollment Broker with questions about the process, including how to obtain the Enrollment Broker's standardized form for requesting an MCE change.

- Procedures for making complaints, recommending changes in policies and services, and contacting the Member Advocate for assistance;
- Information about advance directives as described in Section 4.7.5;
- Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats;
- Information on how to contact the Hoosier Care Connect Enrollment Broker;
- Statement that Contractor 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 Contractor's provider incentive plans will be provided;
- The process by which an Indian 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;
- The copayment system, schedule, and exemptions outlined in Section 12; and
- The process by which a member can receive a waiver by calling the 24-hour Nurse Call Line prior to utilizing a hospital Emergency department.

4.4.3 Member ID Card

The member ID card shall at a minimum include the member's name and FSSA assigned Member ID number. No other identification number may be shown on the member ID card.

4.5 Member Disenrollment

In accordance with 42 CFR 438.3(d)(3), the Contractor may neither terminate enrollment nor encourage a member to disenroll because of his or her health care needs or a change in health care status. A member's health care utilization patterns may not serve as the basis for disenrollment from the Contractor.

The Contractor must notify the DFR, in the manner prescribed by the State, within thirty (30)

calendar days of the date it becomes aware of the death of one of its members, giving the member's full name, address, Social Security Number, member identification number and date of death. The Contractor will have no authority to pursue recovery against the estate of a deceased Medicaid member.

4.6 Member-Contractor Communications

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

The Contractor shall maintain strategies for communicating with members. Contractor communication strategies must meet the requirements of this Section 4 and provide innovative approaches to ensure member understanding of the Hoosier Care Connect program. The Contractor shall also develop approaches to increase member awareness of their health condition(s), treatment protocols and the importance of preventive care. The Contractor should work with Indiana DCS to locate wards or foster children when contact information on record is not current.

4.6.1 Member Services Helpline and 24 Hour Nurse Line

The Contractor shall maintain a statewide dedicated toll-free member services helpline staffed with trained personnel knowledgeable about the Hoosier Care Connect program. Helpline staff shall be equipped to handle a variety of member inquiries.

The member services helpline shall be staffed and accessible via live voice coverage, at minimum for twelve (12) hours per day, Monday through Friday, from 8 a.m. to 8 p.m. Eastern Standard Time. Beginning one (1) year after the Contract effective date, the Contractor may request FSSA approval to modify the hours of operation of the member services helpline based on call center traffic data. FSSA retains sole discretion for approval or denial of such requests. The Contractor shall provide a voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned the following business day.

The member services helpline may be closed on the following holidays:

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

For all days with a closure, members must have access to the twenty-four (24) hour nurse call line described below. Call center closures shall not burden a member's access to care.

The Contractor shall provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members. The Contractor shall also describe any additional technology to be leveraged to communicate with hearing impaired members. Additionally, the member services helpline must offer language translation services for members whose primary language is not English. Automated telephone menu options must be made available in English and Spanish.

The Contractor must have the ability to warm transfer members to outside entities including the Enrollment Broker, DFR and provider offices. Additionally, the Contractor shall ensure the warm transfer of calls for members that require attention from a Contractor care manager. The Contractor shall ensure the care manager has access to all information necessary to resolve the member's issues. Any messages left with care managers must be returned by the next business day.

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

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

- Access to health care services and Hoosier Care Connect benefits;
- Identification or explanation of covered services;
- Special health care needs;
- Procedures for submitting a member grievance or appeal;
- Potential fraud or abuse;
- Changing PMPs;
- Incentive programs;
- Disease management, care management and complex case management services;
- Health crises, including but not limited to, suicidal callers; and
- Balance billing issues; and
- Referrals to local services or community-based organizations for assistance.

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

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

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

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

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

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

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

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

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

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

In addition to the member services helpline which is staffed during regular business hours, the Contractor shall operate a toll-free twenty-four (24) hour nurse call line. The Contractor shall provide nurse triage telephone services for members to receive medical advice twenty-four (24) hours-a-day/seven (7)-days-a-week from trained medical professionals. The twenty-four (24) hour nurse call line should be well publicized and designed as a resource to members to help discourage inappropriate Emergency room use. The twenty-four (24) hour nurse call line must have a system in place to communicate all issues with the member's providers. In addition, as set forth in Section 3.3.1, the 24-Hour Nurse Call Line must be equipped to provide advice and copayment waivers for Hoosier Care Connect members seeking services from hospital Emergency departments.

4.6.2 Electronic Communications

The Contractor shall identify how they intend to leverage technology in their member outreach strategies.

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

The Contractor shall respond to questions and concerns submitted by members electronically within one (1) business day. If the Contractor is unable to answer or resolve the member's question or concern within one (1) business day, the Contractor

must notify the member that additional time will be required and identify when a response will be provided. A final response must be provided within three (3) business days.

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

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

4.7 Member Information, Education and Outreach

4.7.1 Member and Stakeholder Education and Engagement

The Contractor must convene local and regional member and patient advocacy organization advisory committees and develop strategies to facilitate member participation at least quarterly. The Contractor shall maintain methods to facilitate member and member advocacy organization participation, for example, providing transportation, interpretation services, or personal care assistance. The Contractor shall invite patient advocacy organizations to each meeting, especially focusing on organizations with a focus on special health care needs such as ARC of Indiana, Covering Kids and Families, About Special Kids, and Family Voices. The Contractor must establish a goal related to member engagement in the Quality Management and Improvement Program Work Plan described in Section 7.1.2.

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

4.7.2 General Member Information Requirements

The Contractor shall comply with the information requirements at 42 CFR 438.10. All enrollment notices, informational and instructional materials must be provided in a manner and format that is easily understood. This means, to the extent feasible, written materials shall not exceed a fifth-grade reading level.

All written materials shall be provided in English and Spanish, and any additional prevalent languages identified by FSSA, upon FSSA's or the member's request. At the time of enrollment with the Contractor, the State shall provide the primary language of each member. The Contractor shall utilize this information to ensure communication materials are distributed in the appropriate language. The Contractor shall also identify

additional languages that are prevalent among the Contractor's membership. For purposes of this requirement, prevalent language is defined as any language spoken by at least three percent (3%) of the general population in the Contractor's service area or three percent (3%) of the Contractor's membership in a region. Written information must be provided in any such prevalent languages identified by the Contractor. Per Section 1557 of the Affordable Care Act / 45 CFR 92.1, Contractor shall ensure that for significant publications and communications taglines (short statements written in non-English languages to alert individuals with limited English proficiency to the availability of language assistance services, free of charge, and how the services can be obtained) must be included in the State's top 15 languages spoken by limited English proficient populations, and for small-size significant publications and significant communications a tagline must be included in the State's top two languages spoken by limited English proficient populations. The Contractor must notify all members that translated written information is available and provide information on how to access. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.

Additionally, written materials must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. This includes but is not limited to Braille, large font, audiotape and verbal explanations of written materials. The Contractor shall offer braille as an alternative format for receiving member materials. When a member has requested materials in braille, the Contractor shall supply future materials in braille to the member. The Contractor may review with the member the specific documents types the member wishes to receive in braille versus other formats. The Contractor may outreach to members to inquire if braille documents are still the desired format. All members and potential members must be informed that information is available in alternative formats and how to access those formats.

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

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

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

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

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

and additional mailings at the will of the Contractor, such as a wellness visit reminder postcard.

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

The Contractor must provide notification to FSSA, the Enrollment Broker and to its members of any covered services that the Contractor or any of its subcontractors or networks do not cover on the basis of moral or religious grounds and guidelines for how and where to obtain those services, in accordance with 42 CFR 438.102. This information must be relayed to the member before and during enrollment and within ninety (90) calendar days after adopting the policy with respect to any particular service. Refer to Section 7.3.2 for additional information.

The Contractor must notify all members of their right to request and obtain information in accordance with 42 CFR 438.10. In addition to providing the specific information required at 42 CFR 438.10(f) upon enrollment in the Enrollment Packet as described in Section 4.4, the Contractor must notify members at least once a year of their right to request and obtain this information. Written notice must be given to each member of any significant change in this information at least thirty (30) calendar days before the intended effective date of the change. Significant change is defined as any change that may impact member accessibility to the Contractor's services and benefits.

Grievance, appeal and fair hearing procedures and timeframes must be provided to members in accordance with 42 CFR 438.10(g)(2)(xi). Section 4.12 provides further information about procedures and information that the Contractor must provide to members regarding grievances and appeals.

The Contractor must make a good faith effort to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis. Such notice must be provided to members at least thirty (30) calendar days prior to the effective date of the termination. However, if the practice or practitioner notifies the Contractor less than 30 days prior to the effective date of the termination, the Contractor shall then notify members as soon as possible but no later than 15 calendar days after receipt of the notification from the practice or practitioner. Additionally, upon the request of a member, the Contractor shall also provide information on the structure and operation of the health plan as well as information on physician incentive plans. In the first and third quarter of every Contract year, the Contractor shall identify members who are potentially eligible for the Supplemental Nutritional Assistance Program (SNAP). The Contractor shall use the federal poverty level of 130% to identify potentially eligible members. The Contractor shall conduct an educational outreach campaign to the members identified as potentially eligible. The Contractor does not need to outreach to all potentially eligible members at once, but can conduct outreach on a rolling basis during the quarter identified and the following quarter (e.g., reach out to each potentially eligible member once in the first or second quarter and once again in the third or fourth quarter of every Contract year). The educational information provided to members shall include information on SNAP benefits, eligibility, and how to enroll.

The Contractor 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 Contractor must provide information requested by the State, or the State's designee, for use in member education and enrollment, upon request.

4.7.3 Oral Interpretation Services

In accordance with 42 CFR 438.10(d), the Contractor must arrange for oral interpretation services to its members free of charge for services it provides, including:

- Member services helpline as described further in Section 4.6.1;
- Twenty-four (24) hour nurse call line;
- Transportation;
- Assessment and stratification;
- Disease management;
- Care management;
- Complex case management; and
- Right Choices Program.

The requirement to provide oral interpretation applies to all non-English languages, and is not limited to prevalent languages discussed in Section 4.7.2. Oral interpretation services must also include sign language interpretation services for the deaf. The Contractor must notify its members of the availability of these services and how to obtain them.

Additionally, the Contractor 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 twenty-four (24) hour access to healthcare-related services in their service locations or via telephone (e.g., hospital Emergency departments, PMPs) must provide members with twenty-four (24) hour oral interpreter services, either through interpreters or telephone services. For example, the Contractor must ensure that network providers provide TDD services for hearing impaired members, oral interpreters, and signers.

4.7.4 Cultural Competency

In accordance with 42 CFR 438.206, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Per 42 CFR 438.204, at the time of enrollment with the Contractor, the State shall provide the race, ethnicity and primary language of each member. This information shall be utilized by the Contractor to ensure the delivery of culturally competent services. The Contractor will utilize Community Health Workers as part of broader community health integration initiatives and promotion of culturally competent care.

4.7.5 Advance Directive Information

The Contractor must maintain written policies and procedures concerning advance directives which meet the requirements set forth in Subpart I of 42 CFR 489. Advance directives are defined in 42 CFR 489.100 as "a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health

care when the individual is incapacitated." Written policies must include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. Such statement must clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians, identify the state legal authority permitting such objection and describe the range of medical conditions or procedures affected by the conscience objection.

Per 42 CFR 438.3(j), the Contractor must provide adult members with written information on advance directive policies, including a description of applicable state law. This information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change. Written information must include their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. This information must be provided at the time of initial enrollment. If the member is incapacitated at the time of initial enrollment and is unable to receive information or articulate whether or not he or she has executed an advance directive, the information may be given to the member's family or surrogate. Once the member is no longer incapacitated or unable to receive such information, the Contractor must ensure the information is given to the individual directly at the appropriate time. Members must also be informed that complaints concerning noncompliance with the advance directive requirements may be filed with the State. See 42 CFR 422.128 for further information regarding these requirements.

4.7.6 Member Website

The Contractor shall provide and maintain a website for members to access information pertaining to the Hoosier Care Connect program and the Contractor's services. The website must be in an FSSA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines. The Contractor shall submit any website content and graphic presentations to the FSSA for review and acceptance prior to posting the information on the website in accordance with the requirements of Section 4.9. The website must be accurate and current, culturally appropriate, written for understanding at a fifth-grade reading level and available in English and Spanish. The Contractor must inform members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website 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 Contractor must make a version available in a format that is optimized for mobile phone use.

The Contractor must date each web page, change the date with each revision and allow users print access to the information. The website must include the information required in the Enrollment Packet as described in Section 4.4. Additionally, at minimum, the following shall be posted on the website:

- Information about the cost and quality of health care services, as further described in Section 4.7.8;
- A description of the Contractor's disease management, care management and complex case management programs;
- Contractor-distributed literature regarding all health or wellness promotion programs that are offered by the Contractor;
- A searchable provider directory identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access and

other demographic information as described in Section 4.4.1, which shall be updated at a minimum every two (2) weeks;

- The HIPAA privacy statement;
- Links to FSSA's website for general Medicaid, Hoosier Care Connect information, and referrals to local community-based organizations for assistance;
- Non-emergency Medical Transportation access information;
- A list and brief description of each of the Contractor's member outreach and education materials;
- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report;
- The Contractor's contact information for member inquiries, grievances and appeals;
- The Contractor's member services phone number, TDD number, hours of operation and after-hours access numbers, including the twenty-four (24) hour nurse call line;
- Preventive care and wellness information;
- Member rights and responsibilities as outlined in 42 CFR 438.100 and as detailed in Section 4.10;
- Member handbook information as outlined in Section 4.4.2;
- Information on behavioral health covered services and resources;
- A secure portal through which members may complete the health screening described in Section 5.1.1.; and
- Information about the copayment system and schedule outlined in Section 12.

4.7.7 Preventive Care Information

The Contractor is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care standards. This shall include reminders that encourage members to obtain the recommended preventive services for their age, gender and pre-existing conditions. For members under twenty-one (21), this includes information on EPSDT, well-child services and blood lead screenings. Further information on education requirements for disease specific conditions and disease management, care management and complex case management communications is provided in Section 5.2. The Contractor shall, on an ongoing basis, contact via all appropriate media any member who has not utilized preventive services or has no claims activity within the last 15 months to schedule preventive care.

4.7.8 Cost and Quality Information

Making cost and quality information available to members increases transparency and has the potential to reduce costs and improve quality. The Contractor must make cost and quality information available to members in order to facilitate more responsible use of health care services and inform health care decision-making. Examples of cost

information include average cost of common services and urgent versus emergent care costs.

For services which may be at risk for improper payments, the Contractor must develop processes to verify with members that said targeted services billed by providers were actually received by said members, in order to obtain direct verification of services rendered and increase oversight. Contractor's processes and procedures must be identified in Contractor's Program Integrity Plan, identified in section 7.4.1. Specific services for member verification may be identified by the OMPP PI Section and may change based upon fraud trends. Processes for verifying services with members shall be included in the Contractor's Program Integrity Plan.

The Contractor shall provide a member portal with access to electronic EOB statements for Hoosier Care Connect members.

Provider quality information must also be made available to members beginning in the second calendar year of the Contract. The Contractor must capture quality information about its network providers, and must make this information available to members. In making the information available to members, the Contractor shall identify any limitations of the data. The Contractor must also refer members to quality information compiled by credible external entities such as CMS Hospital Compare or Leapfrog Group.

The Contractor shall maintain strategies to provide cost and quality information to members and specify if explanation of benefits (EOBs) will be provided.

4.8 Member-Provider Communications

In accordance with 42 CFR 438.102, the Contractor may not prohibit, or otherwise restrict a health care professional, acting within his or her lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; or
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

This provision does not require the Contractor to provide coverage for a counseling or referral service if the Contractor objects to the service on moral or religious grounds in accordance with 42 CFR 438.102. The Contractor may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

4.9 Member and Potential Member Communications Review and Approval

All member and potential member communications required in this Section 4 or otherwise developed by the Contractor must be pre-approved by FSSA. The Contractor must develop and include a Contractor-designated inventory control number on all member marketing, education, training, outreach and other member materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate FSSA's review and approval of member materials and document its receipt and approval of original and revised documents.

The Contractor shall submit all member and potential member communications, including

letters, bulletins, forms, advertisements, notices, handbooks, brochures and any other marketing, educational or outreach materials to FSSA for review and approval at least thirty (30) calendar days prior to expected use and distribution. Changes to member and potential member communications must also be submitted to FSSA for review and approval at least thirty (30) calendar days prior to use.

The Contractor shall not refer to or use the FSSA or other state agency name or logo in its member and potential member communications without prior written approval of the State. The Contractor must request approval from FSSA in writing for each desired reference or use at least thirty (30) calendar days prior to the reference or use. Any approval given for the FSSA or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval. The Contractor shall include the State Hoosier Care Connect program logo in their marketing or other member communication materials upon FSSA request.

FSSA will impose remedies as outlined in Contract Exhibit 2 Contract Compliance and Pay for Outcomes for the Contractor's non-compliance in the use or distribution of any non-approved member or potential member communications.

All FSSA-approved member and potential member communication materials must be available on the Contractor's member website within three (3) business days of distribution.

4.10 Member Rights

Per 42 CFR 438.100, the Contractor shall guarantee the following rights to members:

- The right to receive information in accordance with 42 CFR 438.10;
- The right to be treated with respect and with due consideration for his or her dignity and privacy;
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- The right to participate in decisions regarding his or her health care, 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 on the use of restraints and seclusion;
- The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526; and
- The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

The Contractor shall also comply with other applicable state and federal laws regarding member rights, as set forth in 42 CFR 438.100(d). The Contractor must have written policies in place regarding the protected member rights listed above. The Contractor shall have a plan in place to ensure that its staff and network providers take member rights into account when furnishing services to the Contractor's members. Members shall be free to exercise protected

member rights, and the Contractor must not discriminate against a member that chooses to exercise his or her rights.

4.11 Redetermination Assistance

The Contractor shall assist members in the eligibility redetermination process. Permitted assistance includes:

- Conducting outreach calls or sending letters to members reminding them to renew their eligibility and reviewing redetermination requirements with the member;
- Answering questions about the redetermination process; and
- Helping the member obtain required documentation and collateral verification needed to process the application.

In providing assistance during redetermination, Contractor shall not do any of the following:

- Discriminate against members, including particularly high-cost members or members that have indicated a desire to change MCEs;
- Talk to members about changing MCEs;
- All requests to change MCEs shall be referred to the Enrollment Broker. However, if during the outreach process the member raises a concern and would like to change MCEs due to the concern, the Contractor shall attempt to resolve the member's concern. If the member remains dissatisfied with the outcome, the Contractor shall refer him or her to the Enrollment Broker;
- Provide any indication as to whether the member will be eligible (this decision must be made by DFR employees);
- Engage in or support fraudulent activity in association with helping the member complete the redetermination process;
- Sign the member's redetermination form; or
- Complete or send redetermination materials to DFR on behalf of the member.

Contractors shall provide redetermination assistance equally across the membership and demonstrate to FSSA that their redetermination-related procedures are applied consistently for each member. In accordance with the State's status as a 1634 state, SSI members are automatically enrolled in Medicaid without a separate application required to Medicaid. Eligibility in Medicaid for SSI recipients is maintained without the need for an annual Medicaid redetermination. Therefore, the Contractor shall ensure redetermination assistance activities are not provided to SSI members.

4.12 Member Inquiries, Grievances & Appeals

The Contractor shall establish written policies and procedures governing the resolution of inquiries, grievances and appeals. At a minimum, the grievance system must include a grievance process, an appeals process, expedited review procedures and access to external grievance procedure as well as the State's fair hearing system. The Contractor shall maintain records of grievances and appeals in accordance with 42 CFR 438.416.

The State will review this information as part of the State's quality strategy. The Contractor's grievances and appeals system, including the policies for recordkeeping and reporting of grievances and appeals, must comply with law, including 42 CFR 438, Subpart F as well as IC 27-13-10 and IC 27-13-10.1 (if the Contractor is licensed as an HMO) or IC 27-8-28 and IC 27-8-29 (if the Contractor is licensed as an accident and sickness insurer).

The term inquiry refers to a concern, issue or question that is expressed orally by a member that will be resolved by the close of the next business day.

The term grievance, as defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an "adverse benefit determination" as defined below. This may include dissatisfaction related to the quality of care of services rendered or available, aspects of interpersonal relationships such as rudeness of a provider or employee or the failure to respect the member's rights.

The term appeal is defined as a request for a review of an action. An adverse benefit determination, as defined in 42 CFR 438.400(b) is any of 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 excluding the denial of a claim that does not meet the definition of a clean claim. A "clean claim" is one in which all information required for processing the claim is present;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of a Contractor to act within the required timeframes;
- For a resident of a rural area with only one Contractor, the denial of a member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network (if applicable); or
- Denial of a member's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

The Contractor must notify the requesting provider, and give the member written notice, of any decision considered an "adverse benefit determination" taken by the Contractor, including any decision by the Contractor to deny a service authorization request (a request for the provision of a service by or on behalf of a member), or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404 and must include:

- The adverse benefit determination the Contractor has taken or intends to take;
- The reasons for the adverse benefit determination;
- The member's or the provider's right to file an appeal and the procedure for requesting such an appeal;
- The procedure to request an external grievance procedure (External Review by

Independent Review Organization) following exhaustion of the Contractor appeals process;

- The procedure to request a State fair hearing following exhaustion of the Contractor appeals process;
- The circumstances under which expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending resolution of the appeal, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services.

4.12.1 Contractor Grievance and Appeals Policies

The Contractor's policies and procedures governing grievances and appeals must include provisions which address the following:

- The Contractor must not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member, in accordance with 42 CFR 438.102. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.
- The Contractor must not take punitive action against a provider who requests or supports an expedited appeal on behalf of a member.
- Throughout the appeals process, the Contractor must consider the member, representative or estate representative of a deceased member as parties to the appeal.
- In accordance with 42 CFR 438.406, provide the member and his representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents or records considered during the appeals process.
- Allow the member and member representative to present evidence, and allegations of fact or law, in person as well as in writing.
- Inform the member and member representative of the limited time available to present evidence and allegations of fact or law, in the case of expedited appeal resolution.
- Upon determination of the appeal, ensure there is no delay in notification or mailing to the member and member representative of the appeal decision. The Contractor's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).
- The Contractor must acknowledge receipt of each grievance and appeal.
- The Contractor must notify members of the disposition of grievances and appeals pursuant to IC 27-13-10-7 (if the Contractor is licensed as an HMO) or IC 27-8-28-16 (if the Contractor is licensed as an accident and sickness insurer).

- The Contractor must provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

- The Contractor must ensure that the individuals rendering decisions on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise (medical, surgical or diagnostic expertise as pertinent to case) in treating the member's condition or disease if the decision will be in regard to any of the following:

    - An appeal of a denial based on lack of medical necessity;

    - A grievance regarding denial of expedited resolution of an appeal; and

    - Any grievance or appeal involving clinical issues.

4.12.2 Inquiry Processing Requirements

The Contractor shall resolve inquiries by the close of the next business day after receipt. If an inquiry is not resolved in this timeframe it becomes a grievance. An inquiry resolved in the required timeframe does not require a written notice of resolution to the member. The Contractor shall maintain a system for tracking and reporting inquiries it receives during business and non-business hours.

4.12.3 Grievance Processing Requirements

In accordance with 42 CFR 438.402, members must be allowed to file grievances orally or in writing. Members may file a grievance regarding any matter other than those described in the definition of an adverse benefit determination as described in Section 4.12. Grievances must be filed within sixty (60) calendar days of the occurrence of the matter that is the subject of the grievance.

The Contractor must acknowledge receipt of each grievance within three (3) business days. The Contractor must make a decision on non-expedited grievances as expeditiously as possible, but not more than thirty (30) calendar days following receipt of the grievance. This timeframe may be extended up to fourteen (14) calendar days if resolution of the matter requires additional time. If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. The Contractor shall provide the member with a written notice of any extension within two (2) calendar days of the extension, including the reason for the extension and the member's right to file a grievance if they disagree with the extension.

The Contractor shall provide an expedited grievance review if adhering to the resolution timeframe of thirty (30) calendar days would seriously jeopardize the life or health of a member, or the member's ability to regain maximum function. Expedited grievances must be resolved within forty-eight (48) hours of receipt. If the Contractor denies a request for an expedited review, the Contractor shall transfer the grievance to the standard grievance timeframe. Further, the Contractor must make a reasonable effort, including a phone call to the member, to provide the member with prompt oral notification of the denial for an expedited review, and shall follow up with a written notice to the member and, where appropriate, the provider within two (2) calendar days.

The Contractor shall respond in writing to a member within five (5) business days after resolving a grievance or expedited grievance. The resolution includes notice of the member's right to file an appeal, the process for requesting an appeal, the expedited review options, the right to continue benefits during the appeal (as long as the request complies with timeliness standards), and an explanation that the member may have to pay for care received if an adverse appeal decision is made. The Contractor must make a reasonable effort, including a phone call to the member, to provide oral notification of expedited grievance resolution.

4.12.4 Appeals Processing Requirements

Members shall have sixty (60) calendar days from the date of adverse benefit determination notice to file an appeal. In accordance with 42 CFR 438.402, a provider, acting on behalf of the member, and with the member's written consent, may file an appeal. In accordance with 42 CFR 438.406, the Contractor shall ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. For oral appeals with expedited resolutions the Contractor shall maintain documentation of the oral appeal and its resolution.

The Contractor must acknowledge receipt of each standard appeal within three (3) business days. The Contractor must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay.

The Contractor shall maintain an expedited review process for appeals when the Contractor or the member's provider determines that pursuing the standard appeals process could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Contractor must dispose of expedited appeals within forty-eight (48) hours after the Contractor receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c). In accordance with 42 CFR 438.410, if the Contractor denies the request for an expedited resolution of a member's appeal, the Contractor must transfer the appeal to the standard thirty (30) calendar day timeframe and give the member written notice of the denial within two (2) days of the expedited appeal request. The Contractor must also make a reasonable attempt to give the member prompt oral notice, including a phone call to the member.

In accordance with 42 CFR 438.408, written notice of appeal disposition must be provided to the member and, where appropriate, the provider. Notice shall be provided within five (5) business days of resolution. For notice of an expedited resolution, the Contractor must also make reasonable efforts, including a phone call to the member, to provide oral notice. The written notice of the resolution must include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice must include the right to request an external grievance procedure (External Review by Independent Review Organization) and State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. This shall also include notice that the member may be held liable for the cost of those benefits if the State hearing upholds the Contractor's adverse benefit determination as set forth in Section 4.12.7.

4.12.5 External Review by Independent Review Organization

In accordance with IC 27-13-10.1-1 and IC 27-8-29-1, the Contractor shall maintain an external grievance procedure for the resolution of decisions related to an adverse

utilization review determination, an adverse determination of medical necessity, or a determination that a proposed service is experimental or investigational. Members must first exhaust the Contractor's grievance and appeals process. An external review does not inhibit or replace the member's right to appeal a Contractor decision to a State fair hearing. A member may seek external review by an IRO, and such process may run concurrently with a State fair hearing.

Within one hundred and twenty (120) calendar days from the date of the Contractor's decision, a member, or a member's representative may file a written request for a review of the Contractor's decision by an independent review organization (IRO). The IRO shall render a decision to uphold or reverse the Contractor's decision within seventy-two (72) hours for an expedited appeal, or fifteen (15) business days for a standard appeal. The determination made by the independent review organization is binding on the Contractor. IRO clinicians do not have to be Indiana licensed.

4.12.6 State Fair Hearing Process

In accordance with 42 CFR 438.408, the State maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions to the State. Refer to 405 IAC 1.1 for the appeal procedures for applicants and recipients of Medicaid.

Members must first exhaust the Contractor's grievance and appeals process. The Contractor must timely coordinate the grievance and appeal process. Within one hundred and twenty (120) calendar days of exhausting the Contractor's internal procedures, the member may request a FSSA fair hearing.

The parties to the FSSA fair hearing shall include the Contractor, as well as the member and his or her representative or the representative of a deceased member's estate. If dissatisfied with the outcome of the FSSA fair hearing, the member may request an agency review within ten (10) days of the administrative law judge's decision. An agency decision may be brought before a judicial review pursuant to 405 IAC 1.1-3-1. The Contractor will be subject to the contract compliance remedies (set forth in Exhibit 2 Contract Compliance and Pay for Outcomes) for failing to provide a timely and satisfactory response to documentation required for an appeal or failure to represent the state at the FSSA fair hearing.
The Contractor must include the external grievance procedure (External Review by Independent Review Organization) and the FSSA fair hearing process as part of the written internal process for resolution of appeals and must describe the processes in the member handbook described in Section 4.4.2. All notices of actions with appeal rights and notices of final action by the Contractor where the next course of action is a State Fair Hearing shall have the following language included:
"This is an administrative action by the State of Indiana. If you disagree with this decision, you can appeal it. Appeals are handled by the State of Indiana Office of Administrative Law Proceedings. You may mail your request for a state fair hearing to the State of Indiana Office of Administrative Law Proceedings at:

Office of Administrative Law Proceedings
402 W. Washington St., Room E034
Indianapolis, IN 46204"

4.12.7 Continuation of Benefits Pending Appeal & Reinstatement of Benefits

In certain member appeals, the Contractor will be required to continue the member's benefits pending the appeal, in accordance with 42 CFR 438.420. The Contractor must continue the member's benefits if:

- The member or provider files the appeal within ten (10) days of the Contractor mailing the notice or the intended effective date, whichever is later;

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

- The services were ordered by an authorized provider;

- The original period covered by the original authorization has not expired; and

- The member requests extension of benefits.

If benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the request for appeal;

- Ten (10) days pass after the Contractor 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 ten (10) days; or

- The time period or service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the member, that is, it upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements to maintain benefits in accordance with 42 CFR 431.230 and 42 CFR 438.420. In accordance with Section 4.12.8, the Contractor shall notify the member in advance that costs may be recovered.

In accordance with 42 CFR 438.424, if the Contractor or State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services.

4.12.8 Member Notices of Action & Grievance, Appeal and Fair Hearing Procedures

The Contractor must provide specific information regarding member grievance, appeal, external grievance procedure (External Review by Independent Review Organization), and State fair hearing procedures and timeframes to members, as well as providers and subcontractors at the time they enter into a contract with the Contractor. This information shall be included in the Member Handbook as described in Section 4.4.2. The information provided must be approved by FSSA in accordance with Section 4.9 and, as required under 42 CFR 438.10(g)(2)(xi), include the following:

- The right to file grievances and appeals;

- The requirements and timeframes for filing a grievance or appeal;

- The availability of assistance in the filing process;

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

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

- In the case of an FSSA fair hearing:

  - The right to a hearing;

  - The method for obtaining a hearing; and

  - The rules that govern representation at the hearing.

4.13 Member Cost Sharing

The Contractor shall adhere to State and Federal law, the State Plan and the requirements set forth in 42 CFR 447.50 through 447.57 when imposing any cost sharing charges on members.

Federal regulations at 42 CFR 447.78 place aggregate limits on cost-sharing and prohibit total member cost-sharing per family from exceeding five percent (5%) of the family's income, as determined by the State, in a monthly or quarterly period.

To ensure a family's total cost-sharing does not exceed five percent (5%) of the family's income in a calendar quarter, the Contractor shall accept family income data from the State's fiscal agent and track the copayments, premiums, member debt collected, and/or other cost-sharing information available to the Contractor against the total family income data provided by the State. Any service not specifically listed as a covered benefit in the applicable benefit plan may not be applied against the member's five percent (5%) contribution calculation. The time period for tracking data shall be defined by the State. When a family's total cost-sharing expenditures come close to exceeding five percent (5%) of the family's income in the quarterly period, the Contractor shall coordinate with the State and shall notify providers and the family that additional cost sharing during the period is reduced or waived.

In monitoring the quarterly 5% member cost-sharing limit, the Contractor shall comply with the policies and procedures set forth in this section, as well as the additional policies and procedures included in the Hoosier Care Connect MCE Policies and Procedures Manual.

5.0 Care Coordination

5.1 Member Assessment

5.1.1 Initial Screening

The Contractor shall conduct an initial screening of each member within ninety (90) calendar days of the effective date of enrollment to identify the member's immediate physical and/or behavioral health care needs. The Contractor must make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful. The Contractor shall make attempts to find a member's current contact information if it is not included in the enrollment file. The initial

screening will also determine the need for disease management, care management, complex case management, or RCP services as detailed in Section 5.2. The Contractor shall utilize the FSSA Health Needs Screening tool.

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

At minimum, the initial screening shall:

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

The initial screening may be conducted in person, by phone, electronically through a secure website, or by mail. Incomplete initial screenings completed electronically through the Contractor's secure website will receive follow up telephone contacts to promote completion of the initial health screening. The Contractor shall develop procedures and provide documentation of methods to be used to maximize contacts with members in order to complete the initial screening required in this Section. The Contractor should work with Indiana DCS to locate wards or foster children when contact information on record is not current.

Based on the results of the initial screening, the Contractor shall stratify members into the appropriate service category - those members requiring disease management, care management, complex case management, or RCP, in accordance with Section 5.2. After stratifying the member to an appropriate care level, the Contractor shall provide ongoing disease management, care management, or complex case management, as appropriate.

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

5.1.2 Comprehensive Health Assessment

The Contractor shall conduct a comprehensive health assessment of all members initially stratified into care management, complex case management or RCP following the initial screening in order to further identify the appropriate level of care coordination services. The comprehensive health assessment will be all-inclusive and identify the clinical, psychosocial, functional and financial needs of the member to ensure appropriate referrals to MCE program and community-based organizations. The comprehensive health assessment shall be completed within one hundred and fifty (150) calendar days of enrollment, and will be used to develop and implement a comprehensive care plan to meet the member's needs. The Contractor shall develop and maintain efficient processes and collaborative relationships with Indiana DCS to encourage caregivers of wards or foster children to complete the comprehensive health assessment.

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

The Contractor will collect and review medical and educational information, as well as family and caregiver input, as appropriate, to identify the member's care strengths, health needs and available resources. The comprehensive assessment may include, but is not limited to, a review of the member's claims history and/or contact with the member, member's family, PMP (if applicable), or other significant providers. A clinician on the Contractor's care management team will review the findings of the health assessment and provide the findings to the member's primary providers, including the member's PMP and/or behavioral health care providers, if applicable.

The Contractor must maintain methods to maximize contacts with members in order to complete the comprehensive health assessments required in this Section 5.1.2.

5.1.3 Identification and Assessment of Pregnant Women

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

Health Workers, to physically make contact. These contacts must be documented by the Contractor and available for State review as requested.

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

Further, FSSA has implemented a Notification of Pregnancy (NOP) process that encourages MCEs and providers to complete a comprehensive risk assessment (i.e., an NOP form) for pregnant members. The Contractor shall comply with the policies and procedures set forth in the IHCP Provider Bulletin regarding the NOP process dated May 22, 2014 (BT201425), and any updates thereto.

The provider will be responsible for completing the standard NOP form, including member demographics, any high-risk pregnancy indicators, and basic pregnancy information. The Contractor receiving the NOP shall contact the member to complete a comprehensive pregnancy health assessment within twenty-one (21) calendar days of receipt of completed NOP form from the provider. The Contractor shall also gather clinical data from relevant health information exchanges to supplement claims data mining, NOPs, and self-reports of pregnancy. Only one assessment should be completed per member per pregnancy. NOP requirements and conditions for payment are set forth in the Hoosier Care Connect Policies and Procedures Manual.

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

The Contractor shall have systems and procedures in place to accept NOP data from the State's fiscal agent, assign pregnant members to a risk level and, when indicated based on the member's assessment and risk level, enroll the member in care coordination, as described in Section 5.0. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the IHCP Provider Healthcare Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent.

5.2 Stratification & Level of Service

Based on the results of the initial screening as well as mining of historical claims data and clinical data from health information exchanges, the Contractor shall stratify its membership into various subpopulations to identify member level of service and ensure continuity of care. The outcome of the member assessment set forth above in Section 5.1 will determine the member's needs in the stratification process resulting in the member's assignment to one of the levels of care coordination service, set forth below in this Section 5.2.

Prior to the Contract's effective date, the Contractor will propose to FSSA a stratification methodology, which shall include a "rush" designation for members with immediate needs. The stratification plan must be approved by FSSA prior to member stratification. In addition, the care coordination classification system may be modified if the Contractor receives written approval from FSSA.

5.2.1 Disease Management Level of Service

Disease management is intended to help guide the care of members with chronic health conditions to improve the quality of care, adherence to care and control health care costs.

Supporting the practitioner-member relationship and plan of care, the disease management program will emphasize the prevention of the exacerbation of the condition and its complications using evidenced based practice guidelines.

The Contractor shall offer, at minimum, asthma, depression, pregnancy, attention deficit hyperactivity disorder (ADHD), autism/pervasive developmental disorder, chronic obstructive pulmonary disease (COPD), coronary artery disease, chronic kidney disease, congestive heart failure, hypertension, diabetes, and SUD disease management programs for eligible members. The Contractor may propose, for FSSA approval, programs for additional conditions. Members with excessive utilization or under-utilization for conditions other than those listed shall also be eligible for the disease management level of service described in this Section.
Disease management services should assist members in understanding their chronic conditions, set goals, and achieve self-selected outcomes through education, counseling, and on-going support. The Contractor will provide a customer call line for provider and community information, linkage to community resources and disease specific and general preventive health education and reminders for members. Disease management services must be provided to members with specific conditions and for prevention of related conditions. For example, disease management services for members diagnosed with diabetes or hypertension must include education for the member on kidney disease and the benefits of having evaluations and treatment for chronic kidney disease.
Disease management services may be provided by non-clinical staff with escalation to clinical staff as indicated by provider request or change in clinical status. Through disease management services, the Contractor will provide information and specific preventive care reminders, resources, and referrals as requested by members, member advocates, and health care providers. The Contractor will promote evidenced-based practices for chronic disease conditions.
The Contractor will provide information, resources and referrals as needed to all members, their families and health care providers, as requested. Disease management services shall include policies and procedures that encourage all new members to have a preventive care visit within sixty (60) calendar days of the member's effective date of enrollment and ongoing member outreach as indicated for the entire population.

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

5.2.2 Care Management Level of Service

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

Care management is a purposeful plan to reach members and impact their health and health care utilization, and to coordinate all services provided to members. Through care management, the Contractor assists members in improving their health outcomes. Members who are at risk for an acute or catastrophic episode in the future may be prioritized for complex case management services. In the interim care management

services will be provided as a preventive measure. The Contractor will provide comprehensive coordination services that are tailored to the individual, rely on sound medical practices, and include Medicaid-covered services. All members identified for care management services will receive all of the benefits of disease management services in addition to the additional care management supports.

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

The Contractor must make every effort to contact members in care management by telephone. The Contractor shall use community health workers to physically make contact when members cannot be reached via telephone within a predetermined, State approved timeframe. Should such attempts fail, the Contractor shall develop a plan for how to reach members (including outreach to providers, repeated physical outreach, etc.). Materials should be delivered to the member in a manner in accordance with the member's selection as outlined in Section 4.6.2, either through postal or electronic means direct to the consumer. Educational materials and telephonic contacts may utilize web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth-grade reading level and in accordance with all member communication requirements outlined in Section 4.7.2, and should be sent to members no less than quarterly. The Contractor shall consider utilizing the services of community health workers, as appropriate, to outreach to and provide information to those members participating in care management. The Contractor will be required to submit quarterly and annual data to document the number of persons receiving care management services, including the number of active and passive contacts made to the member.

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

5.2.3 Complex Case Management (Member Focus) Level of Service

Complex case management with member focus involves the active coordination of care and services with the member and between providers while navigating the extensive systems and resources required for the member. It includes comprehensive assessment, determination of available benefits, development and implementation of a complex case management plan directed at the member's chronic health conditions. Complex case management targets members with two (2) or more disease states who need assistance with care coordination, making preventive care appointments or accessing care to address the members' chronic health condition or members who have had an inpatient hospital stay in the last ninety (90) days or members with high dollar claims of over fifty

thousand $50,000 thousand dollars (>$50,000) in six (6) months. The focus is on working with the providers to meet the needs of the individual through communication with the member, PMP (if applicable), other providers, and the member's natural support system. The member's active involvement will help members gain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

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

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

5.2.4 Complex Case Management (Provider Focus) Level of Service

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

Complex case management with provider focus is the active coordination by the Contractor of care and services between providers while navigating the extensive systems and resources required for the member. It involves comprehensive assessment, determination of available benefits, development and implementation of a complex case management plan directed at the chronic health conditions.
At a minimum, the Contractor must provide complex case management services for members discharged from an inpatient psychiatric, drug overdose, or substance abuse hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization discharge. The Contractor must also provide complex case management services for any member at risk for inpatient psychiatric or substance abuse re-hospitalization. Care managers must contact members during an inpatient hospitalization or as soon as practicable upon receiving notification of a member's inpatient behavioral

health hospitalization. The care manager must work with the hospital discharge planner, provider case manager and/or natural supports (i.e. family) to ensure that an outpatient follow-up appointment is scheduled to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge and transportation is not a barrier to attending the appointment.

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

5.2.5 Right Choices Program Level of Service

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

Program policies, set forth by the FSSA for the RCP, are delineated in the Right Choices Program Policy Manual. The Contractor shall comply with the program policies set forth in the Right Choices Program Policy Manual, which is provided in the Bidders' Library. The Contractor shall be responsible for RCP duties for their members, as outlined in the Right Choices Program Policy Manual, including, but not limited to, the following:

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

- Cooperate with FSSA in evaluation activities of the program by providing data and/or feedback when requested by FSSA;

- Meet with FSSA about RCP program implementation as requested by FSSA; and

- Develop, for FSSA approval, and implement internal policies and procedures regarding the Contractor's RCP program administration.

5.3 Care Plan Development

After the initial assessment and stratification, the Contractor shall assign members to a care level, develop a care plan for each member, and facilitate and coordinate the holistic care of each member according to his or her needs. The Contractor shall utilize a person-centered care plan development planning process. All identified pregnant women who agree to either care management or complex case management shall have a care plan developed in conjunction with the Contractor.

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

The Contractor will assist the member, the member's family and the member's physician(s) to develop a care plan with specific objectives, goals and action protocols to meet identified needs. In the case of wards, foster children and former foster children, the Contractor will also collaborate with Indiana DCS, stakeholders such as community-based service providers, the judicial system, advocates, physical and behavioral health providers, caregivers (including adoptive family or biological family as appropriate) and schools through Individual Education Plans (IEP), in the development of the care plan. The Contractor will initiate and facilitate specific activities, interventions and protocols that lead to accomplishing the goals set forth in the care plan, and shall be responsible for developing strategies to facilitate timely and secure communication and information sharing between providers, caregivers, and stakeholders.

The care plan will include, at a minimum:

- Clinical history and pertinent family history;

- Diagnosis(es);

- Functional and/or cognitive status;

- Medical Equipment and Medical Equipment Suppliers;

- Immediate service needs;

- Use of services not covered by the program;
- Accommodation needs (e.g., special appointment times, alternative formats) and auxiliary aids and services;
- Barriers to care (i.e. language, transportation, etc.);
- PMP, if applicable;
- Care/case manager from a service delivery system, for members with one;
- Psychosocial support resources;
- Local community resources;
- Family member/caregiver/facilitator resources and contact information;
- Behavioral health status;
- Intensity of services;
- Assigned case coordinator for disease management, care management, complex case management, or RCP;
- Member self-management goals;
- Clearly identified, member-centered, and measurable long-term goals and objectives;
- Clearly identified, member-centered, and measurable short-term goals and objectives;
- Key milestones towards meeting short-term and long-term goals and objectives;
- Planned interventions and contacts with member, providers and/or service delivery system;
- Assessment of progress, including input from family, if appropriate; and
- Resources to support foster parents with healthcare coordination, as applicable.

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

- Pain;
- Trouble sleeping;
- Anxiety / depression;
- Medications – poly-pharmacy and gaps in prescription refills;
- Skin;
- Bowel / bladder;

- Transitions;
- Health Maintenance – preventive care;
- Health Maintenance – chronic disease management;
- Mobility;
- Nutrition;
- Advance care planning;
- Caregiver burden;
- Oral health;
- Avoiding unwanted pregnancy;
- Preventing choking from inappropriate supervision with eating;
- Appropriate gait evaluation and adaptive equipment use to prevent fractures;
- Assisting wards and foster children with healthcare coordination during transitions including, but not limited to, placement changes and aging out of foster care; and
- Adjustment to new placement and relationships, in the case of wards and foster children.

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

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

Care plans will delineate a variety of "low touch" and "high touch" interventions and approaches ranging from member educational mailings, telephone contacts with members

and providers, face-to-face visits, in-home visits, and telephonic outreach. Interventions may range from passive mailings for preventive care reminders to home visits by the care manager. The Contractor shall maintain a State approved care plan and indicate which interventions and approaches will be used. The care plan shall also describe successful interventions and approaches used to gain maximum benefit for each care coordination stratification level.

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

5.3.1 Disease Management Care Plans

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

5.3.2 Care Management Care Plans

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

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

The Contractor will engage the member's PMP (if applicable) or other significant provider(s) in care management through ongoing, direct interaction between the provider and the multidisciplinary care management team. This involvement will include semi-annual care conferences based on the member's assessment and evaluation. The Contractor will offer to travel to the provider's office to conduct the care conference, or conduct it via teleconference, at the provider's option. A minimum of two (2) weeks prior to each care conference, the Contractor will solicit input from the member's provider for updating the care plan and consideration for appropriate stratification. Contractors shall reimburse providers for their time at these care conferences as described further in Section 3.5.

5.3.3 Complex Case Management Care Plans

Complex case management services are defined by multiple medical needs, high risk issues such as significant deterioration in health status or ongoing lack of self-management skills due to personal issues, cognitive impairment, mental illness, lack of social supports, or multiple co-morbidities. Complex case management care plans will include all elements of disease management and care management, as well as higher levels of support. The Contractor will use a multi-disciplinary team skilled in nursing,

social work and behavioral health, with knowledge of local community resources to implement protocol-driven care modules for members. Care plans will delineate the frequency and mode of contacts with members, minimally monthly. Care plans will incorporate additional expertise as needed based on the person's health conditions, disabilities, pharmacy, and other urgent management needs.

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

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

The Contractor will engage the member's PMP (if applicable) and other significant providers in complex case management activities through ongoing, direct interaction between the provider(s) and the multidisciplinary care management team. This involvement will include semi-annual case conferences based on the member's assessment and evaluation. The Contractor will offer to travel to the provider's office to conduct the care conference, or conduct it via teleconference, at the provider's option. A minimum of two (2) weeks prior to each case conference, the Contractor will solicit input from the member's PMP for updating the care plan, consideration for appropriate stratification and participation in the conference. Contractors shall reimburse providers for their time at these care conferences as described further in Section 3.5. The Contractor must evaluate all members determined to need complex case management services during a home visit where the Contractor can assess the member's environment and available resources.

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

5.3.3.1 Complex Case Management- Member Focus

Care plans for members who actively participate in case management and in need of complex case management services will include a focus on communication with the PMP (if applicable), other providers, and the member's natural support system, with emphasis on the responsibilities and actions of the member. The complex case management plan will identify the problems, barriers and issues related to the individual's health care needs and identify strategies for best engaging the member in his/her own treatment. It will address goals, objectives and interventions to meeting the needs of the individual.

5.3.3.2 Complex Case Management- Provider Focus

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

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

5.3.4 RCP Care Plans

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

5.4 Reassessments

The Contractor will develop a process for reviewing and updating the care plans with members on an as-needed basis, but no less often than annually. It is expected that members in complex case management and RCP will have care plans reviewed and updated on a schedule more often than annually. The Contractor shall assess wards and foster children as they transition to new placements and age out of foster care. Additionally, the Contractor shall be responsible for accepting notifications from DCS when a child has had a change in foster home placement due to extenuating circumstances, including but not limited to, trauma or neglect-related cases. The Contractor shall coordinate with DCS to assure any necessary health and trauma screenings when there is a change in foster home placement.

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

6.0 Provider Network Requirements

The Contractor shall develop and maintain a provider network in compliance with the terms of this section. Individuals with disabilities and chronic health conditions often spend years finding providers with the appropriate clinical knowledge and competencies to meet their needs. The Contractor shall implement strategies to ensure the maintenance of these established provider relationships and develop a network able to handle the special health care needs of the Hoosier Care Connect population. In accordance with 42 CFR 438.3(l) the Contractor must allow each member to choose his or her health professional to the extent possible and appropriate. The Contractor must ensure that its provider network is supported by written provider agreements, is available and geographically accessible and provides an adequate number of facilities, physicians, pharmacies, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members, in accordance with 42 CFR 438.206. The Contractor must also ensure that all of its contracted providers can respond to the cultural, racial and linguistic needs of its members.

The Contractor must ensure all network providers who, in accordance with IHCP policy, are provider types eligible and required to enroll as an IHCP provider, are enrolled IHCP providers. In some cases, members may receive out-of-network services. In order to receive reimbursement from the Contractor, out-of-network providers must be IHCP providers. The Contractor shall encourage out-of- network providers, particularly emergency services providers, to enroll in the IHCP. Further information about IHCP Provider Enrollment is located at: https://www.in.gov/medicaid/providers/451.htm.

6.1 Network Development

FSSA requires the Contractor to develop and maintain a comprehensive network to provide services to its Hoosier Care Connect members. The Contractor must develop a comprehensive network prior to the effective date of the Contract and prior to receiving enrollment. The Contractor shall be required during the Readiness Review process to demonstrate network adequacy through the submission of Geo Access reports and provider lists in the manner and timeframe required by FSSA. The Contractor shall be required to have an open network and accept any IHCP provider acting within his or her scope of practice until the Contractor demonstrates that it meets the access requirements. FSSA reserves the right to delay initial member enrollment in the Contractor's plan if the Contractor fails to demonstrate a complete and comprehensive network.

With approval from FSSA, Contractors that can demonstrate that they have met all access, availability and network composition requirements may require members to use in-network providers, with the exception of certain self-referral providers as described in Section 3.1. Additionally, as described in Section 3.15, during the first ninety (90) calendar days of the Contract, the Contractor shall be required to permit members to continue receiving services from a non-network provider even if FSSA has approved closure of the network.

If a member seeks covered services from an in-network provider that does not provide those services due to moral or religious objections, with the member having no other in-network provider options, the Contractor must have a process by which the member can seek services from an out-of-network provider.

In accordance with 42 CFR 438.206, the Contractor must maintain and monitor the provider network. The Contractor will establish written agreements with all network providers as further described in Section 6.5. In establishing and maintaining the network, the Contractor must consider the following:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of the Contractor's Hoosier Care Connect enrollment and anticipated enrollment;
- The number and types (in terms of training, experience, specialization, and expertise in foster care issues, pediatrics, and behavioral health) of providers required to furnish the contracted services;
- The number of network providers who are not accepting new members;
- The proximity to public transportation and/or the reliance upon non-emergency medical transportation; and

- The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.

The Contractor must provide ninety (90) calendar days advance notice to FSSA of changes to the network that may affect access, availability and network composition. FSSA will regularly and routinely monitor network access, availability and adequacy. FSSA will impose remedies, as set forth in Contract Exhibit 2 Contract Compliance and Pay for Outcomes, or require the Contractor to maintain an open network, if the Contractor fails to meet the network composition requirements.

6.2 Network Composition Requirements

In compliance with 42 CFR 438.207, the Contractor 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; and
- Maintain a sufficient number, mix and geographic distribution of providers as specified below.

At the beginning of its Contract with the State, the Contractor shall submit regular network access reports as directed by FSSA. Once the Contractor demonstrates compliance with FSSA's access standards, the Contractor shall submit network access reports on a quarterly basis and at any time there is a significant change to the provider network (i.e., the Contractor no longer meets the network access standards).

In accordance with 42 CFR 438.12, the Contractor may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor 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 does not require the Contractor to contract with providers beyond the number necessary to serve the members' needs. Contractors are also not precluded from using different reimbursement amounts for different specialties or practitioners within the same specialty. Finally, it does not preclude the Contractor from establishing quality and cost control measures.

As required under 42 CFR 438.206, the Contractor must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members, if the Contractor also serves commercial members. The Contractor must also make covered services available twenty-four (24)-hours-a-day, seven (7)-days-a-week, when medically necessary. In meeting these requirements, the Contractor must:

- Establish mechanisms to ensure compliance by providers;
- Monitor providers regularly to determine compliance; and
- Take corrective action if there is a failure to comply.

The Contractor must develop a plan to monitor high risk providers, such as transportation providers, to ensure the safety of the member and reliability of service.

The Contractor must provide FSSA written notice at least ninety (90) calendar days in advance of the Contractor's inability to maintain a sufficient network in any county. FSSA reserves the right to expand or revise the network requirements, as it deems appropriate.

For purposes of the subsections below, "urban areas" are counties not designated by HRSA as a rural county. "Rural areas" are those areas designated by HRSA as a rural county.

6.2.1 Acute Care Hospital Facilities

The Contractor 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 thirty (30) miles in urban areas and sixty (60) miles in rural areas. Exceptions must be justified and documented to the State on the basis of community standards for accessing care.

6.2.2 Inpatient Psychiatric Facilities

The Contractor 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 sixty (60) miles. Exceptions must be justified and documented to the State on the basis of community standards for accessing care.

6.2.3 Primary Medical Providers (PMP)

The Contractor is not required to institute a PMP model under which all members select or are assigned to a single provider responsible for coordinating care and making referrals to specialists. The Contractor shall maintain mechanisms to coordinate care for members, including, but not limited to, the use of PMPs or other alternative models. If a PMP model is used, the Contractor shall describe the types of providers eligible to serve as a PMP, any panel size limits or requirements, and policies and procedures to link members to PMPs. At a minimum, providers allowed to serve as PMPs must include physicians, physician assistants, and advanced practice registered nurses (APRNs). Regardless of if a PMP model is utilized, the Contractor must demonstrate compliance with 42 CFR 438.208. Specifically, the Contractor must ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as primarily responsible for coordinating the health care services furnished to the member.

If a PMP model is utilized by the Contractor, providers may contract as a PMP with one (1) or multiple Hoosier Care Connect MCEs. A PMP may also participate as a specialist in another MCE. The PMP may maintain a patient base of non-Hoosier Care Connect members (e.g., commercial, traditional Medicaid, Hoosier Healthwise or Healthy Indiana Plan (HIP)). The Contractor may not prevent the PMP from contracting with other MCEs.

Regardless of if a PMP model is utilized, the Contractor must ensure the availability of a physician to serve as the ongoing source of care appropriate to the member's clinical condition within at least thirty (30) miles of the member's residence. The Contractor shall meet this requirement regardless of if a PMP model is utilized.

The Contractor must have a mechanism in place to ensure that these physicians provide or arrange for coverage of services twenty four (24)-hours-a day, seven (7)-days-a-week and that contracted physicians have a mechanism in place to offer

members direct contact with their provider, or the provider's qualified clinical staff person, through a toll-free telephone number twenty four (24)- hours-a-day, seven (7)-days-a-week. Each provider must be available to see members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations. The Contractor must also assess the provider's non-Hoosier Care Connect practice to ensure that the provider's Hoosier Care Connect population is receiving accessible services on an equal basis with the provider's non-Hoosier Care Connect population.

The Contractor must ensure that contracted providers serving as the ongoing source for member's care provide "live voice" coverage after normal business hours. After-hours coverage may include an answering service or a shared-call system with other medical providers. The Contractor must ensure that members have telephone access to their provider (or appropriate designee such as a covering physician) in English and Spanish twenty-four (24)-hours-a-day, seven (7)-days-a-week.

The Contractor must ensure that providers are maintaining the medical care standards and practice guidelines detailed in the appropriate IHCP provider reference module. The Contractor 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.

For members that transition from the Contractor's other Indiana Medicaid lines of business, including but not limited to children covered under Hoosier Healthwise who become wards of the State or foster children, the Contractor shall establish internal operational mechanisms to utilize PMP assignment information from the other line of business in considering PMP assignment in Hoosier Care Connect.

6.2.4 Specialist and Ancillary Providers

The Contractor must provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers. The providers are not limited to serve in only one (1) MCE network. In addition, physicians contracted as a PMP (if applicable) with one (1) MCE may contract as a specialist with other MCEs.

The Contractor must ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the appropriate IHCP provider reference module. FSSA requires the Contractor to monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

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EXHIBIT 1.A.
SCOPE OF WORK

FSSA requires the Contractor to develop and maintain a comprehensive network of specialty providers listed below. For providers identified with an asterisk (*), the Contractor must provide, at a minimum, two (2) specialty providers within sixty (60) miles of the member's residence. For providers identified with two (2) asterisks (**), the Contractor must provide, at a minimum, one specialty provider within ninety (90) miles of the member's residence.

Specialist	Ancillary Providers
• Anesthesiologists* • Cardiologists* • Cardiothoracic surgeons** • Dermatologists** • Endocrinologists* • Gastroenterologists* • General surgeons* • Hematologists • Infectious disease specialists** • Interventional radiologists** • Nephrologists* • Neurologists* • Neurosurgeons** • Non-hospital-based anesthesiologist (e.g., pain medicine)** • OB/GYNs* • Occupational therapists* • Oncologists* • Ophthalmologists* • Optometrists* • Orthopedic surgeons* • Orthopedists • Otolaryngologists • Pathologists** • Physiatrists* • Physical therapists* • Podiatrists* • Psychiatrists* • Pulmonologists* • Radiation oncologists** • Rheumatologists** • Speech therapists* • Urologists*	• Diagnostic testing* • Durable Medical Equipment • Home Health • Prosthetic suppliers**

FSSA requires that the Contractor maintain different network access standards for the listed ancillary providers as follows:

- Two (2) durable medical equipment providers must be available to provide services to the Contractor's members in each county or contiguous county; and

- Two (2) home health providers must be available to provide services to the Contractor's members in each county or contiguous county.

The contractor must demonstrate the availability of providers with experience in serving wards and foster children. These providers should have expertise in caring for victims of child abuse and neglect, as well as the provision of trauma informed care, and should have training regarding the impact of trauma on effective assessment, treatment planning, and integration of physical and behavioral health care and services.

In addition, the Contractor must demonstrate the availability of providers with training, expertise and experience in providing tobacco dependence treatment. Evidence that providers are trained to provide tobacco dependence treatment must be available during FSSA's monthly onsite visits.

The Contractor must contract with the Indiana Hemophilia and Thrombosis Center or a similar FSSA-approved, federally recognized hemophilia treatment center.

The Contractor must arrange for laboratory services only through those IHCP enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

6.2.5 Non-Psychiatrist, Non-Substance Use Disorder (SUD) Behavioral Health Providers

In addition to the access requirements for psychiatrists as described in Section 6.2.4, the Contractor shall establish a network of behavioral health providers, addressing mental health, including the following:

- Outpatient mental health and addiction clinics;
- Community mental health centers;
- Health service providers in psychology (HSPP);
- Licensed clinical social workers;
- Psychiatric nurses;
- Independent practice school psychologists;
- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing;
- Marital and family therapists; and
- Licensed mental health counselors.

The Contractor is required to contract with CMHCs who are certified by the FSSA Division of Mental Health and Addiction (DMHA). If all CMHCs are not included in the provider network, the Contractor must demonstrate that this does not prevent coordination of care with MRO and 1915(i) State Plan HCBS services as required in Sections 3.12.1 and 3.12.2. Further, as described in Section 3.10.2, the Contractor 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 Contractor must provide at least one (1) behavioral health provider able to treat adults and children within thirty (30) minutes or thirty (30) miles from the member's residence. The Contractor must provide assertive outreach to members in rural areas where behavioral health services may be less available and must monitor utilization to assure equality of service access and availability.

All outpatient mental health services must be delivered by licensed psychiatrists and HSPPs, or an advanced practice nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling.

6.2.6 SUD Providers

The Contractor shall establish a network of SUD treatment providers that provide the continuum of the American Society of Addiction Medicine (ASAM) levels of care. These providers should provide the following levels of treatment:

- Early intervention
- Outpatient
- Intensive outpatient
- Partial hospitalization
- Clinically-managed low-intensity residential
- Clinically managed high-intensity residential
- Medically-managed inpatient

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

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

6.2.7 Dental Providers

The Contractor shall maintain a network of dental providers. The Contractor must ensure the availability of an adult general dentistry provider and pediatric dentistry provider within thirty (30) miles of the member's residence. This can include dental providers who provide service within a federally qualified health center (FQHC). The Contractor is encouraged to maintain a network of specialty dentists, including endodontists, oral surgeons, orthodontists, and periodontists.

6.2.8 County Health Departments

FSSA strongly encourages the Contractor to contract or enter into business agreements with any health departments that are willing to coordinate with the Contractor and are able to meet the Contractor's credentialing and service delivery requirements.

6.2.9 Urgent Care Clinics

The Contractor shall affiliate or contract with urgent care clinics. Urgent care clinics shall be made available no less then eleven (11) hours each day Monday through Friday and no less than five (5) hours each day on the weekend.

6.2.10 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

FSSA strongly encourages the Contractor to contract with all willing FQHCs and RHCs that meet the credentialing and service delivery requirements. The Contractor must reimburse FQHCs and RHCs for services at no less than the level and amount of payment that the Contractor would make to a non-FQHC or non-RHC provider for the same services. Additionally, in accordance with section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), the Contractor shall pay an out-of-network Indian healthcare provider (see Section 6.2.13) that is an FQHC at a rate equal to the amount of payment that the Contractor would pay to an in-network FQHC that is not an Indian health care provider for the same services.

In accordance with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), FSSA will make supplemental payments to FQHCs and RHCs that subcontract (directly or indirectly) with the Contractor. These supplemental payments represent the difference, if any, between the payment to which the FQHC or RHC would be entitled for covered services under the Medicaid provisions of BIPA and the payments made by the Contractor.

FSSA requires the Contractor to identify any performance incentives it offers to the FQHC or RHC. FSSA must review and approve any performance incentives. The Contractor must report all such FQHC and RHC incentives which accrue during the Contract period related to the cost of providing FQHC-covered or RHC-covered services to its members along with any fee-for-service and/or capitation payments in the determination of the amount of direct reimbursement paid by the Contractor to the FQHC or RHC.

The Contractor shall perform quarterly claims reconciliation with each contracted FQHC or RHC to identify and resolve any billing issues that may impact the clinic's annual reconciliation conducted by FSSA.

Annually, FSSA requires the Contractor to provide the Contractor's utilization and reimbursement data for each FQHC and RHC in each month of the reporting period. The report must be completed in the form and manner set forth in the Reporting Manual. The submitted FQHC and RHC data must be accurate and complete. The Contractor must pull the data by NPI, rather than other means, such as a Federal Tax ID number. The Contractor shall establish a process for validating the completeness and accuracy of the data, and a description of this process must be available to FSSA upon request. The claims files should not omit claims for practitioners rendering services at the clinic nor should the files contain claims for practitioners who did not practice at the clinic.

In addition, FSSA requires the FQHC or RHC and the Contractor to maintain and submit records documenting the number and types of valid encounters provided to members each month. Capitated FQHCs and RHCs must also submit encounter data (e.g., in the form of shadow claims to the Contractor) each month. The number of encounters will be subject to audit by FSSA or its representatives.

The Contractor shall work with each FQHC and RHC in assisting FSSA and/or its designee in the resolution of disputes concerning year-end reconciliations between the federally required interim payments (made by FSSA to each FQHC and RHC

on the basis of provider reported encounter activity) and the final accounting that is based on the actual encounter data provided by the Contractor.

6.2.11 Pharmacies

The Contractor shall establish a network of pharmacies. The Contractor must provide at least two (2) pharmacy providers within thirty (30) miles or thirty (30) minutes from a member's residence in each county.

6.2.12 Other Providers

FSSA encourages the Contractor to contract or affiliate with other safety net providers such as community health centers. Additionally, the Contractor is encouraged to develop relationships with school-based health centers (SBHC) with the goal of providing accessible quality preventive and primary health care services to school-aged members.

6.2.13 Physician Extenders

A physician extender (PE) is a licensed health care provider who is not a physician but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.

In accordance with Indiana law, the following physician extenders are licensed to provide care in Indiana:

- Advanced practice registered nurses, including nurse practitioners, nurse midwives and clinical nurse specialists;
- Physician assistants; and
- Certified registered nurse anesthetists.

The Contractor shall implement initiatives to encourage providers to use physician extenders. Examples of these types of initiatives include, but are not limited to:

- Educating providers about the benefits of physician extenders;
- Educating providers about reimbursement policies for physician extenders; and
- Offering financial or non-financial incentives to providers who increase their use of physician extenders. Any financial incentives must be positive, not punitive.

State Medicaid programs are required to make nurse practitioner services available to Medicaid recipients in accordance with 42 CFR 441.22. The Contractor shall permit members to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the Contractor's network. If nurse practitioner services are available through the Contractor, the Contractor must inform the member that nurse practitioner services are available.

The Contractor shall allow advanced practice registered nurses and physician assistants to serve as primary medical providers (PMPs).

6.2.14 Indian Healthcare Providers

Section 5006 of ARRA provides certain protections for Indian health care providers in Medicaid. An Indian health care provider means a health care program, including providers of contract health services, operated by the Indian Health Service (IHS) or an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). The Contractor shall offer to enter into contracts with Indian health care providers participating in Medicaid that reflect the provisions in this Section 6.2.13.

In accordance with section 5006(d) of ARRA, the Contractor shall:

1. Permit any Indian member who is eligible to receive services from a participating Indian healthcare provider to choose to receive covered services from that Indian healthcare provider, and if that Indian healthcare provider participates in the network as a PMP (if applicable), to choose that Indian healthcare provider as his or her PMP, as long as that Indian healthcare provider has the capacity to provide the service;

2. Demonstrate that there are sufficient Indian healthcare providers in the Contractor's network to ensure timely access to services available under the Contract for Indian members who are eligible to receive services from such providers. CMS intends to issue regulations regarding sufficiency of Indian healthcare providers in states like Indiana where few Indian healthcare providers are available. The Contractor shall be held to these standards;

3. Reimburse Indian healthcare providers, whether in-or out-of-network, for covered services provided to Indian members who are eligible to receive services from such providers either at 1) a rate negotiated between the Contractor and the Indian healthcare provider, or 2) 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;

4. Make prompt payment to all Indian healthcare providers as set forth in Section 8.5.3; and

5. 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 Indian member by the amount of a copayment or other cost-sharing that would be due from the Indian member if not otherwise prohibited under Section 5006(a) of ARRA.

Section 5006(d) of ARRA requires that the State provide a supplemental payment to non-FQHC Indian healthcare providers for covered services provided to Indian members. The amount of the supplemental payment is the difference, if any, of the rate paid by the Contractor for the services and the rate that applies to the provision of such services under the state plan, which is the encounter rate determined by IHS in the annual federal register notice. To the extent FSSA requires utilization and/or reimbursement data from the Contractor to make a supplemental payment to an Indian healthcare provider, the Contractor shall provide the requested data within thirty (30) calendar days of the request.

6.2.15 Non-Emergency Medical Transportation Providers

In accordance with 42 CFR 440.170 the Contractor 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.

6.3 Provider Accessibility

The Contractor shall implement policies and procedures related to network provider accessibility. This shall include establishing timeliness standards for scheduling appointments based on provider type and the urgency of the member's need (e.g., routine or urgent) and maximum in-office wait times. These standards shall be submitted to the State for review and approval. Additionally, The Contractor shall maintain methods for monitoring these requirements.

6.4 Provider Enrollment and Disenrollment

The Contractor shall be responsible for meeting all provider screening and enrollment requirements described in 42 CFR 455 Subpart E.

The Contractor is prohibited from contracting with providers who have been or have had owners or operators (i.e., those with a controlling interest) excluded from the Federal Government or by the State's Medicaid program for fraud or abuse. The Contractor, as well as its subcontractors and providers, whether contract or non- contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any services provided by excluded individuals shall be refunded to and/or obtained by the State and/or the Contractor as prescribed in section 7.4 Program Integrity Overpayment Recovery. Where the excluded individual is the provider of services or an owner of the provider, all amounts paid to the provider for services rendered following their exclusion shall be refunded. The Contractor shall be responsible for checking the lists of providers currently excluded by the State and the Federal Government every thirty (30) calendar days.

The Contractor shall capture ownership and control information from its providers required under 42 CFR 455, including 42 CFR 455.104. In addition, Contractor shall also maintain a list of all rendering providers of providers enrolled, even if rendering providers are not required to enroll with IHCP. Rendering providers are defined as those providers that are performing the services for which a provider bills the Contractor or IHCP. The Contractor shall also verify that all rendering providers are not currently excluded by the State and the Federal Government every thirty (30) calendar days. The federal list is available at: http://exclusions.oig.hhs.gov. FSSA reserves the right to immediately disenroll any provider if the provider becomes ineligible to participate in the IHCP. The Contractor shall immediately inform the OMPP PI Section via a written communication should it disenroll, terminate or deny provider enrollment or credentialing for "program integrity" reasons (i.e., the detection and investigation of fraud and abuse).

The Contractor shall follow established procedures to enroll and disenroll providers, including PMPs. The Contractor will provide training to call center care coordination and 24-hour nurse call line staff on locations and hours of urgent care clinics in the plan's network. The HCC MCE Policies and Procedures Manual provides detailed information on PMP and provider enrollment and disenrollment procedures.

To process provider enrollments and disenrollments with the Contractor, the Contractor shall submit the required information to the State fiscal agent through the Portal.

The Contractor shall report PMP disenrollments to the State fiscal agent's Provider Enrollment unit by mail, fax, e-mail or Portal. The Contractor shall first notify the State fiscal agent of the intent to disenroll a PMP within five (5) business days of the receipt/issuance of the PMP's disenrollment. The fiscal agent shall receive enrollment/disenrollment requests at least five (5) business days prior to the 24th day of the month before the date the Contractor

desires the enrollment or disenrollment to become effective. As noted above, the OMPP PI Section should also receive disenrollment notices when they are program integrity related. When advanced notice is not feasible, including, but not limited to, in the event of provider death or exclusion due to fraud or abuse, the Contractor shall submit the disenrollment within five (5) business days of the provider's termination effective date. FSSA shall have the right to take corrective actions if the Contractor does not notify the State fiscal agent in a timely manner.

FSSA shall have the right to immediately disenroll any provider if the provider becomes ineligible to participate in IHCP.

When a PMP disenrolls from HCC, the Contractor shall be responsible for assisting members assigned to that PMP in selecting a new PMP within the Contractor's network. If the member does not select another PMP, the Contractor shall assign the member to another PMP in the Contractor's network before the original PMP's disenrollment is effective.

In accordance with 42 CFR 438.10(f), the Contractor shall make a good faith effort to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis. Such notice shall be provided to members by the later of thirty (30) days prior to the effective date of the termination or within fifteen (15) calendar days of the Contractor's receipt or issuance of the provider termination notice. However, if the practice or practitioner notifies the Contractor less than 30 days prior to the effective date of the termination, the Contractor shall then notify members as soon as possible but no later than fifteen (15) calendar days after receipt of the notification from the practice or practitioner. If a PMP disenrolls from the HCC program, but remains an IHCP provider, the Contractor shall assure that the PMP provides continuation of care for HCC members for a minimum of thirty (30) calendar days or until the member's link to another PMP becomes effective.

The Contractor shall provide the IHCP MCE Practitioner Enrollment Form, IHCP MCE Hospital/Ancillary Provider Enrollment Form or a Contractor specific Network Participation Request Form to providers to complete when requesting to join the Contractor's network. If a Contractor Network Participation Request Form is utilized, it shall include all the information captured on the IHCP MCE Enrollment Forms.

The Contractor shall follow the OMPP network effective date policy for all network participation requests. Providers will be effective with the Contractor on the first of the month following the receipt of a complete network participation request. The Contractor may allow for a brand new provider to be effective the first of the month following the Contract execution. This effective date policy should be followed for all provider types. Providers must be fully enrolled and effective as an IHCP provider prior to becoming effective with the Contractor. The Hoosier Care Connect MCE Policies and Procedures Manual provides detailed information on the provider effective date policy.

The Contractor shall have a central repository solution for all documentation and correspondence that is related to and occurs during the provider network participation process. MCEs must retain the request for participation form, all supporting documents submitted by the provider, all credentialing files, and contract related documents as well as written and email correspondence.

The Contractor shall conduct an annual internal review of the network participation process and determine if there are key inefficiencies that need to be addressed. This includes a review of all components of the provider network participation process and timeliness to complete provider requests.

6.5 Provider Agreements

The Contractor must have a process in place to review and authorize all network provider agreements. The Contractor must submit a model or sample contract of each type of provider agreement to FSSA for review and approval at least sixty (60) calendar days prior to the Contractor's intended use. The Contractor must notify FSSA of any changes to the sample contracts..

The Contractor must include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor must identify and incorporate the applicable terms of the Contract with the State. Under the terms of the provider agreement, the provider must agree that the applicable terms and conditions set out in the Contract 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. All agreements must be governed, construed, and enforced in accordance with the laws of the State of Indiana. Suit, if any, must be brought in the State of Indiana. The requirement set forth in Section 2.3 that subcontracts indemnify and hold harmless the State of Indiana does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

In addition to the applicable requirements for subcontracts in Section 2.3, 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 Contractor's members within ninety (90) calendar days or less from the date of service.
- Include a termination clause stipulating that the Contractor must terminate its contractual relationship with the provider as soon as the Contractor has knowledge that the provider's license or IHCP provider agreement has terminated.
- Terminate the provider's agreement to serve the Contractor's Hoosier Care Connect members at the end of the Contract with the State.
- Monitor providers and apply corrective actions for those who are out of compliance with FSSA's or the Contractor's standards.
- Obligate the terminating provider to submit all encounter claims for services rendered to the Contractor's members while serving as the Contractor's network provider and provide or reference the Contractor's technical specifications for the submission of such encounter data.
- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors.
- Provide the provider the option to terminate the agreement without cause with advance notice to the Contractor. Said advance notice shall not have to be more that ninety (90) calendar days.

- Provide a copy of a member's medical record at no charge upon reasonable request by the member, and facilitate the transfer of the member's medical record to another provider at the member's request.

- Require each provider to agree that it shall not seek payment from the State for any service rendered to a Hoosier Care Connect member under the agreement.

- For behavioral health providers, require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven (7) calendar days from the date of the member's discharge.

- Require each provider to agree to use best commercial efforts to collect required copayments for services rendered to Hoosier Care Connect members.

6.6 Provider Credentialing

The Contractor must have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current state licensure and enrollment in the IHCP. The Contractor's credentialing and re-credentialing process for all contracted providers must meet the NCQA guidelines.

The Contractor shall use the information outlined on IHCP MCE Practitioner Enrollment Form and IHCP MCE Hospital/Ancillary Provider Enrollment Forms during the credentialing process. A copy of this form is provided in the Bidders' Library. The Contractor must ensure that providers agree to meet all of FSSA's and the Contractor's standards for credentialing and maintain IHCP manual standards, including:

- Compliance with state record keeping requirements;

- FSSA's access and availability standards; and

- Other quality improvement program standards.

As provided in 42 CFR 438.214(c), the Contractor'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 Contractor must not employ or contract with providers that have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act. The Contractor shall notify FSSA, in the manner prescribed by the State, of any credentialing applications that are denied due to program integrity-related reasons.

The Contractor shall process all credentialing applications within thirty (30) calendar days of receipt of a complete application. The Contractor shall ensure all credentialed providers are loaded into the Contractor's provider files and claims system within seven (7) business days of credentialing. The Contractor shall set the provider's enrollment date to the initial date the provider's credentialing application was received by the Contractor or State's credentialing vendor.

The Contractor shall outline for providers the information necessary and steps required to be credentialed with the Contractor, including what provider types require credentialing and which do not. This information should be communicated on the Contractor's public facing website and in direct correspondence with providers.

The State will implement a model for provider enrollment and credentialing consistent with

the provisions of IC 12-15-11-9. The Contractor shall comply with all rules, regulations, and policies established.

6.7 Medical Records

The Contractor must assure that its records and those of its participating providers document all medical services that the member receives in accordance with state and federal law. In accordance with 405 IAC 1-1.4-2, the provider's physical or electronic medical record must include, at a minimum:

- The identity of the individual to whom the service was rendered;
- The identity, including dated signature or initials, of the provider rendering the service;
- The identity, including dated signature or initials, and position of the provider employee rendering the service, if applicable;
- Date that the service was rendered;
- Diagnosis of the medical condition of the individual to whom the service was rendered, relevant to physicians and dentists only;
- A detailed statement describing services rendered, including duration of services rendered;
- The location at which services were rendered;
- The amount claimed through Medicaid for each specific service rendered;
- Written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document acute medical needs;
- When required under Medicaid rules, physician progress notes as to the medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and refine goals; and
- X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imagine records.

The Contractor's providers must maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed (manually or electronically) and dated and maintained for at least seven (7) years as required by state and federal regulations.

The Contractor's providers must provide a copy of a member's medical record upon reasonable request by the member at no charge, and the provider must facilitate the transfer of the member's medical record to another provider at the member's request. Confidentiality of, and access to, medical records must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements, including but not limited to, 42 CFR Part 2 specific to confidentiality of alcohol and drug abuse records.

The Contractor's providers must permit the Contractor and representatives of FSSA to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring

quality or any other reason, in accordance with 405 IAC 1-1.4-2. The Contractor shall use technology, including the participation in health information exchanges, where appropriate to transmit and store medical record data.

6.8 Provider Education and Outreach

The Contractor shall provide ongoing education to the provider network on the Hoosier Care Connect program as well as Contractor-specific policies and procedures. In addition to developing its own provider education and outreach materials, the Contractor shall be required to coordinate with FSSA-sponsored provider outreach activities upon request.

The Contractor must educate its contracted providers regarding provider requirements and responsibilities, the Contractor's prior authorization policies and procedures, clinical protocols, caring for vulnerable populations such as wards or foster children, member's rights and responsibilities, claims submission process, claims dispute resolution process, pay-for-outcomes programs and any other information relevant to improving the services provided to the Contractor's Hoosier Care Connect members.

As described in Section 2.15, the Contractor shall notify the State of material changes that may affect provider procedures at least thirty (30) calendar days prior to notifying its provider network of the changes. The Contractor shall give providers at least forty-five (45) calendar days advance notice of material changes that may affect the providers' procedures such as changes in subcontractors, claims submission procedures or prior authorization policies. The Contractor must post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

In accordance with 42 CFR 438.102, the Contractor cannot prohibit or otherwise restrict a health care professional from acting within the scope of his or her practice from advising or advocating on behalf of a member. Contractor communications should communicate this clearly to all providers.

6.8.1 Provider Communications Review and Approval

All provider communication materials required in this section or otherwise developed by the Contractor must be pre-approved by FSSA. The Contractor must develop and include a Contractor-designated inventory control number on all provider communications, including letters, forms, bulletins and promotional, educational, training, informational or other outreach materials, with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate FSSA's review and approval of all provider communications and documentation of its receipt and approval of original and revised documents.

The Contractor must submit all provider communication materials designed for distribution to, or use by, contracted providers to FSSA for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor must also submit any material changes to previously approved provider communication materials to FSSA for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor must receive approval from FSSA prior to distribution or use of materials. FSSA's decision regarding any communication materials is final. The Contractor shall include the State program logo(s) in their provider communication materials upon FSSA request. The Contractor shall have a licensed physician or dentist who practices in Indiana review all provider education or outreach materials. This review shall be conducted prior to submission to FSSA.

The Contractor shall not refer to or use the FSSA or other state agency name or logo in

its provider communications without prior written approval. The Contractor must request in writing approval from FSSA for each desired reference or use at least thirty (30) calendar days prior to the reference or use. Any approval given for the FSSA or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval.

All FSSA-approved provider communication materials must be available on the Contractor's provider website described in Section 6.8.4 within three (3) business days of distribution. The provider communication materials must be organized online in a user-friendly, searchable format by communication type and subject.

6.8.2 Provider Policy and Procedures Manual

The Contractor shall provide and maintain a written Hoosier Care Connect Provider Policies and Procedures Manual for use by the Contractor's network of providers. The Provider Policies and Procedures Manual must be available both electronically and in hard copy (upon request) to all network providers, without cost, when they are initially enrolled, when there are any changes in policies or procedures, and upon a provider's request. The Provider Policies and Procedures Manual shall include, at minimum:

- Hoosier Care Connect benefits and limitations;
- Claims filing instructions;
- Criteria and process to use when requesting prior authorizations;
- Definition and requirements pertaining to urgent and emergent care;
- Participants' rights;
- Providers' rights for advising or advocating on behalf of his or her patient;
- Provider non-discrimination information;
- Policies and procedures for grievances and appeals in accordance with 42 CFR 438.414;
- Frequently asked questions and answers; and
- Contractor and FSSA contact information such as addresses and phone numbers.

The Contractor shall offer Provider Policies and Procedures Manual training to all network providers when they are initially enrolled in the network, whenever there are changes in policies or procedures, and upon a provider's request. Updates or changes in operation that require revisions to the Provider Policies and Procedures Manual shall be submitted to FSSA for review and approval in accordance with the requirements outlined in Section 6.8.1.

6.8.3 Provider Newsletters

The Contractor shall distribute provider bulletins or newsletters not fewer than four (4) times per year that provide updates related to provider services, and policies and procedures specific to the Hoosier Care Connect program. The Contractor shall notify their contracted providers to changes in policy, changes to procedures, and claim

processing errors via the Contractor's bulletins or newsletter in compliance with the Material Change provision in Section 2.15 of this Exhibit.

6.8.4 Provider Website

The Contractor must develop and maintain a website in an FSSA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines for network and out-of-network providers. The website must be live and meet the requirements of this Section on the effective date of the Contract. FSSA must pre-approve the Contractor's website information and graphic presentations. The Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website described in Section 4.7.6.

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 Contractor must date each web page, change the date with each revision and allow users print access to the information. The provider website may have secured information available to network providers but must, at a minimum, have the following information available to all providers:

- Contractor's contact information;
- Provider Policy and Procedure Manual and associated forms;
- Provider communication materials, organized online in a user-friendly, searchable format by communication type and topic;
- Claim submission information including, but not limited to Contractor submission and processing requirements, paper and electronic submission procedures, and frequently asked questions;
- Provider claims dispute resolution procedures for contracted and out-of-network providers;
- Prior authorization procedures, including a complete list of services which require prior authorization;
- Appeal procedures;
- Entire network provider listings;
- Links to FSSA's website for general Medicaid, and Hoosier Care Connect information;
- HIPAA and 42 CFR Part 2 Privacy Policy and Procedures; and
- Network participation request information including all of the information, steps and forms that are required from the provider for a request to join the Contractor's network and be credentialed.

The Contractor shall provide a secure portal for providers to conduct business transactions including, but not limited to electronic claims submission, prior authorization submission, grievance and appeals submission and tracking, etc. This portal must be approved by the State, compliant with all IT requirements identified in Section 8. Information Technology (IT) Systems, and utilize single-sign on capabilities by integrating

with the IHCP Provider Healthcare Portal for access.

6.8.5 Provider Services Helpline

The Contractor shall maintain a toll-free telephone helpline for all providers with questions, concerns or complaints. With the exception of the holidays listed below, the Contractor must staff the provider services helpline with personnel trained to accurately address provider issues, at a minimum for twelve (12) hours per day, Monday through Friday from 8 a.m. to 8 p.m. Eastern Standard Time. Beginning one (1) year after the Contract effective date, the Contractor may request FSSA approval to modify the hours of operation of the provider services helpline based on call center traffic data. FSSA retains sole discretion for approval or denial of such requests. The provider services helpline may be closed on the following holidays: New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas.

For all days with a closure, there shall be a process for providers to process Emergency prior authorizations as needed. Call center closures shall not burden a member's access to care.

The Contractor must maintain a system for tracking and reporting the number and type of provider calls and inquiries. The Contractor must monitor its provider services helpline and report its telephone service performance to FSSA as described in the Reporting Manual.

6.8.6 IHCP Workshops and Seminars

The State fiscal agent sponsors workshops and seminars for all IHCP providers. The Contractor must participate in the workshops and attend the provider seminars. A Contractor representative must be available to make formal presentations and respond to questions during the scheduled time(s). The Contractor is also encouraged to set up an information booth with a representative available during the provider seminars.

6.8.7 Provider Welcome Letter

The Contractor is required to send out a provider welcome letter within five (5) business days of the network participation process completion. The Contractor shall include the standard language provided by OMPP in all provider welcome letters. The standard language includes things such as network effective date, effective date policy, and reference to provider materials. The Contractor may add additional language at the discretion of and approval by OMPP.

The welcome letter should be the final confirmation that the provider is fully enrolled in the Contractor's network and able to render services.

6.9 Payment for Health Care-Acquired Conditions and Provider-Preventable Conditions

In accordance with 42 CFR 438.3(g) and 42 CFR 434.6(a)(12), no payment shall be made by the Contractor to a provider for a provider-preventable condition as identified in the State Plan. The Contractor's policies on non-payment for provider-preventable conditions shall comply with 405 IAC 1-10.5-5. This includes health-acquired conditions as identified by Medicare other than deep vein thrombosis and pulmonary embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients. Other provider-preventable conditions for which the Contractor shall not reimburse include wrong surgical or other invasive procedure on a patient or surgical or other invasive procedure performed on

the wrong body part or wrong patient. Further, in accordance with 42 CFR 447.26(d), the Contractor shall require that as a condition of payment, all providers agree to comply with the reporting requirements in 42 CFR 447.26(d). The Contractor shall comply with any future additions to the list of non-reimbursable provider-preventable conditions.

6.10 Hospital Assessment Fee

Hospital Assessment Fee (HAF) payments will be integrated into capitation rates. Contractors are required to pay HAF hospitals at the enhanced Medicaid rates for HAF eligible services detailed below:

- 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.
    - Non-contracted 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.
- Non-HAF eligible hospitals
    - Contracted providers: MCEs shall pay the amount negotiated with the contracted provider
    - 100% of the Medicaid APR DRG rates for Inpatient and 100% of the Medicaid OP Fee Schedule.
- Non-contracted providers: MCEs shall pay the following:
    - 98% of the Medicaid APR DRG rates for Inpatient and 98% of the Medicaid OP Fee Schedule.

6.11 Member Payment Liability

In accordance with 42 CFR 438.106, the Contractor and its subcontractors must provide that members are not held liable for any of the following:

- Any payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly;
- Covered services provided to the member for which FSSA does not pay the Contractor;
- Covered services provided to the member for which FSSA or the Contractor does not pay the provider that furnishes the services under a contractual, referral or other arrangement; and
- The Contractor's debts or subcontractor's debts, in the event of the entity's insolvency.

The Contractor must ensure that its providers do not balance bill its members. Balance billing is defined as charging the member for covered services above the amount paid to the provider by the Contractor. If the Contractor is aware that an out-of-network, non-IHCP provider, such as an out-of-state Emergency services provider, is balance billing a member,

the Contractor shall instruct the provider to stop billing the member and to enroll in the IHCP in order to receive reimbursement from the Contractor. The Contractor shall also contact the member to help resolve issues related to the billing.

IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered IHCP service. Provider acceptance of payment from the Contractor as payment in full is a condition of participation in the IHCP. An IHCP provider can bill a member only when all of the following conditions have been met:

- The service rendered must be determined to be non-covered by the IHCP.
- The member has exceeded the program limitations for a particular service.
- The member must understand, before receiving the service, that the service is not covered under the IHCP, and that the member is responsible for the charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service. See the *Provider Enrollment* provider reference module for more information.

In cases where prior authorization is denied, a provider can bill a member for covered services if certain safeguards are in place and followed by the provider. The Contractor must establish, communicate and monitor compliance with these procedures, which must include at least the following:

- The provider must establish that authorization has been requested and denied prior to rendering the service;
- The provider has an opportunity to request review of the authorization decision by the Contractor. The Contractor must inform providers of the contact person, the means for contact, the information required to complete the review and the procedures for expedited review if necessary;
- If the Contractor maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that authorization has been denied—if the provider is an out-of-network provider, the provider must also explain that covered services may be available without cost in-network if authorization is provided;
- The member must be informed of the right to contact the Contractor to file an appeal if the member disagrees with the decision to deny authorization;
- The provider must inform the member of member responsibility for payment if the member chooses to or insists on receiving the services without authorization;
- If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:
    - The waiver is signed only after the member receives the appropriate notification.
    - The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.

- Providers must not use non-specific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.

- The waiver must specify the date the services are provided and the services that fall under the waiver's application.

- The provider must have the right to appeal any denial of payment by the Contractor for denial of authorization.

This section should not be interpreted as interfering with a provider's ability to hold members liable for the Emergency services copayment or Hoosier Care Connect member liability for allowable copayment amounts set forth in Section 12.

6.12 Physician Faculty Access to Care (PFAC) Program

Enhanced reimbursement is authorized under the Indiana Physician Faculty Access to Care (PFAC) program.

The program provides enhanced reimbursement for physician services rendered to all of the non-dual Medicaid populations, including those served under risk-based managed care programs, by qualified faculty physicians or other eligible practitioners, as defined in the State Plan.

Eligible physicians and practitioners must be employed by either Indiana University Health, Inc. (IU Health Physicians) or the Sidney and Lois Eskenazi Hospital (Eskenazi Medical Group), also known as the Health and Hospital Corporation of Marion County. The physicians must be affiliated with an in-state medical school, licensed by the State of Indiana, and enrolled as an Indiana Medicaid provider. The program also applies to the following non-physician staff: certified registered nurse anesthetists, nurse practitioners, physician assistants, certified nurse midwives, clinical social workers, clinical psychologists, and optometrists.

Eligible physicians and non-physician staff are eligible for reimbursement at up to the average commercial rate (ACR), with actual enhanced reimbursement subject to annual performance on specified access metrics. Performance payout levels are calculated separately for IU Health Physicians and Eskenazi Medical Group, respectively.

The Contractor is responsible for ensuring PFAC payments are delivered to eligible providers.

7.0 Quality Management and Utilization Management

The Contractor 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 Care Connect program by all providers in all types of settings, in accordance with the provisions set forth in the Contract. In compliance with state and federal regulations, the Contractor must submit quality improvement data, including data that meets Health Plan Effectiveness Data and Information Set® (HEDIS®) standards for reporting and measuring outcomes, to FSSA that includes the status and results of performance improvement projects. Additionally, the Contractor must submit information requested by FSSA to complete the State's Annual Quality Strategy Plan to CMS.

7.1 Quality Management and Improvement Program

The Contractor'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 Contractor's medical and quality improvement staff. Through the Quality Management and Improvement Program, the Contractor must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services to members. As a key component of its Quality Management and Improvement Program, the Contractor will develop incentive programs for both providers and members, with the ultimate goal of encouraging appropriate utilization of health care resources and improving health outcomes of Hoosier Care Connect members.

As a part of the Contractor's Quality Management and Improvement Program, the Contractor shall participate in FSSA's annual performance improvement program. The Contractor must meet the requirements of 42 CFR 438 subpart E and the NCQA, including but not limited to the requirements listed below, in developing its Quality Management and Improvement Work Plan. In doing so, it shall include (1) an assessment of quality and appropriateness of care provided to members with special needs, (2) complete performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects, and (3) produce quality of care reports at least annually.

The Contractor's Quality Management and Improvement Program must:

- Include developing and maintaining an annual Quality Management and Improvement Work Plan which sets goals, establishes specific objectives, identifies the strategies and activities to undertake, monitors results and assesses progress toward the goals.

- Have in effect mechanisms to detect both underutilization and overutilization of services. The activities the Contractor takes to address underutilization and overutilization must be documented and updated annually based on emerging information.

- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.

- Incorporate an internal system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of special needs populations and other quality improvement activities requested by FSSA.

- Participate appropriately in clinical studies, and use HEDIS® measure data and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.

- Collect measurement indicator data related to areas of clinical priority and quality of care. FSSA will establish areas of clinical priority and indicators of care. These areas may vary from one year to the next. The areas will reflect the needs of the Hoosier Care Connect population. Examples of areas of clinical priority include:

    - Behavioral health and physical health care coordination;

    - Emergency room utilization;

    - Access to care;

    - Special needs care coordination and utilization;

    - Hospital utilization;

- Hospitalization for preventable conditions;
- Disease management; and
- Pharmacy utilization.

- Report any national performance measures developed by CMS in the future. The Contractor must develop an approach for meeting the desired performance levels established by CMS upon release of the national performance measures, in accordance with 42 CFR 438.330(a).
- Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector.
- Develop and maintain a physician incentive program as described in Section 7.2.1.
- Develop a member incentive program to encourage members to be personally accountable for their own health care and health outcomes as described in Section 7.2.2.
- Participate in any state-sponsored prenatal care coordination programs.
- Contract for an NCQA-accredited HEDIS audit and report audited HEDIS rates. The HEDIS audit and report must be based upon the NCQA methodology for sampling of HEDIS data.
- Conduct a Consumer Assessment of Health Plans (CAHPS) survey and report survey results to FSSA annually. The CAHPS survey must be based upon the NCQA methodology for sampling of CAHPS data.
- Participate in other quality improvement activities to be determined by FSSA.

7.1.1 Quality Management and Improvement Committee

The Contractor must establish an internal Quality Management and Improvement Committee to develop, approve, monitor and evaluate the Quality Management and Improvement Work Plan and Program. The Contractor's Medical Director must be an active participant in the Contractor's internal Quality Management and Improvement Committee. The Contractor shall outline the composition of its Quality Management and Improvement Committee and demonstrate how the composition is interdisciplinary and appropriately represented to support the goals and objectives of the Quality Management and Improvement Committee.

The Contractor must have appropriate personnel attend and participate in FSSA's regularly scheduled Quality Strategy Committee and Subcommittee meetings. The Contractor is encouraged to recommend attendees to Quality Strategy Committee and Subcommittee meetings. Additionally, the Medical Director or their designee must attend and participate in FSSA's Quality Strategy Committee meetings at least quarterly to update FSSA and report on the Contractor's quality management and improvement activities and outcomes.

The Contractor must have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, the Contractor's internal Quality Management and Improvement Committee, as well as the Quality Management and Improvement Program Work Plan. All functional units in the

Contractor's organizational structure must integrate their performance measures, operational activities and outcome assessments with the Contractor's internal Quality Management and Improvement Committee to support the Contractor's quality management and improvement goals and objectives.

7.1.2 Quality Management and Improvement Work Plan Requirements

The Contractor's Quality Management and Improvement Committee, in collaboration with the Contractor's Medical Director, must develop an annual Quality Management and Improvement Work Plan. The plan must identify the Contractor's quality management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals. The plan should include a specific section related to utilization management measurements. The plan must meet the HEDIS standards for reporting and measuring outcomes. The Contractor shall utilize program data to support the development of the Quality Management and Improvement Work Plan.

The Contractor must submit its Quality Management and Improvement Work Plan to FSSA during the readiness review and annually thereafter. The Contractor shall provide progress reports to FSSA on no less than a quarterly basis. The Contractor must be prepared to periodically report on its quality management activities to FSSA's Quality Strategy Committee or to an appropriate Subcommittee. The Contractor shall prepare the annual Quality Management and Improvement Work Plan using standardized reporting templates provided by FSSA. The Reporting Manual contains more information regarding the annual Quality Management and Improvement Work Plan.

7.1.3 External Quality Review

Pursuant to federal regulations, the State shall arrange for an annual, external independent review of each Contractor's quality of, timeliness of and access to health care services. The Contractor shall provide all information required for this review in the timeframe and format requested by the external quality review organization. The Contractor's Quality Management and Improvement Program should incorporate and address findings from these external quality reviews.

7.2 Incentive Programs

FSSA will require Contractors to participate in a pay for outcomes program that focuses on rewarding the Contractors' efforts to improve quality and outcomes for Hoosier Care Connect members. FSSA will provide, at minimum, financial performance incentives to Contractors based on performance targets in priority areas established by the State. The Contractor incentives and performance targets are set forth in Contract Exhibit 2 Contract Compliance and Pay for Outcomes. FSSA reserves the right to revise measures and will notify the Contractor of changes to incentive measures. The State encourages the Contractors to share earned incentive payments with members and providers

7.2.1 Provider Incentive Programs

Contractors must establish a performance-based incentive system for their providers. The Contractor will determine its own methodology for incenting providers. The Contractor must obtain FSSA-approval prior to implementing its provider incentive program and before making any changes thereto. The State encourages creativity in designing pay for outcomes programs.

If the Contractor 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 438.3(i), 42 CFR 422.208 and 42

CFR 422.210 provide information regarding physician incentive plans. The Contractor must comply with all federal regulations regarding the physician incentive plan and supply to FSSA information on its plan as required in the regulations and with sufficient detail to permit FSSA to determine whether the incentive plan complies with the federal requirements. The Contractor 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 Contractor will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member; and

- The Contractor meets requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.3(i).

7.2.2 Member Incentive Programs

Contractors must establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or nonfinancial. The Contractor will determine its own methodology for incenting members. For example, the Contractor may offer member incentives for:

- 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; or

- Completing a health screening.

Except as provided herein, the Contractor may not offer gifts or incentives greater than fifty dollars ($50.00) for each individual and one hundred dollars ($100.00) per year per individual, unless an exception is approved by OMPP. The Contractor may petition FSSA, in the manner prescribed by FSSA, for authorization to offer items or incentives greater than fifty dollars ($50.00) for each individual and one hundred dollars ($100.00) per year per individual if the items are intended to promote the delivery of certain preventive care services, as defined in 42 CFR 1003.101. Such incentives may not be disproportionate to the value of the preventive care service provided, as determined by FSSA. Petitions to provide enhanced incentives for preventive care shall be reviewed on a case-by-case basis, and FSSA shall retain full discretion in determining whether the enhanced incentives will be approved.

In any member incentive program, the incentives 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. Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and encourage the receipt of health care services in the appropriate treatment setting. The Contractor may stratify receipt of member incentives based upon different

completion rates. For example, the Contractor may provide a member incentive of $50 for completion of the health needs screen within 30 days and a member incentive of $25 if the health needs screen is completed with 31-90 days. Additionally, the Contractor 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 and phone cards. The Contractor must obtain FSSA-approval prior to implementing its member incentive program and before making any changes thereto.

7.3 Utilization Management Program

The Contractor must operate and maintain its own utilization management program. The Contractor may place appropriate limits on coverage on the basis of medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose. The Contractor shall include utilization management measurements in their Quality Management and Improvement Program Work Plan as set forth in Section 7.1.2. The Contractor is prohibited from arbitrarily denying or reducing the amount, duration or scope of required services solely because of diagnosis, type of illness or condition. The Contractor will not refer members to publicly supported health care resources as a means of avoiding costs.

For select fee-for service published criteria or practice guidelines, as identified by the State, the Contractor's utilization management program cannot be more restrictive than the fee-for-service criteria and guidelines. The Contractor shall engage with the State to review already published medically necessary prior authorization criteria.

The Contractor must use non-company customized versions of MCG and InterQual or other commercially available criteria when such products are used for utilization management reviews. The contractor is expected to always use MCG and InterQual for the following utilization management reviews; acute inpatient, skilled nursing facility, acute inpatient rehab, long-term acute care facility and behavioral health inpatient.

For areas not addressed by IHCP criteria and MCG/InterQual, the MCE may develop their own practice guidelines and criteria, but it must be approved by the State and made available to the State. The Contractor must establish and maintain medical management criteria and practice guidelines in accordance with State and federal regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals and consider the needs of the Contractor's members. Pursuant to 42 CFR 438.210(b), the Contractor must consult with contracting health care professionals in developing practice guidelines and must have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with the provider that requested the services when appropriate. Practice guidelines and criteria must be submitted to the State for approval prior to implementation by the Contractor through the standard document review process.

If the Contractor chooses to utilize separate guidelines for physical health and behavioral health services, the Contractor shall demonstrate that the use of separate guidelines would have no negative impact on members, and would not otherwise violate the Contractor's requirements under the Mental Health Parity and Addiction Parity Act (MHPAEA.) Pursuant to 42 CFR 438.210(b), The Contractor's utilization management system should be automated where possible to reduce burden on members and providers, e.g. automatic approvals for certain procedures with diagnoses that are consistent with the treatment. The Contractor must periodically review and update the guidelines, distribute the guidelines to providers and make the guidelines available to members upon request. The Contractor shall maintain utilization management clinical standards, including the use of any nationally recognized evidence-based practices. The State reserves the right to in the future prohibit the Contractor from requiring prior authorization when it is not required in fee-for-service.

Utilization management staff must receive ongoing training regarding interpretation and application of the utilization management guidelines. The Contractor must be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by FSSA. The 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 pended, denied, suspended claims, etc. When adopted, these standards shall be set forth in the Reporting Manual.

The Contractor's utilization management program policies and procedures must meet all NCQA standards and must include appropriate timeframes for:

- Completing initial requests for prior authorization of services;
- Completing initial determinations of medical necessity;
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per state law;
- Notifying providers and members in writing of the Contractor's decisions on initial prior authorization requests and determinations of medical necessity following FSSA forms and templates; and
- Notifying providers and members of the Contractor's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity.

The Contractor must report its medical necessity determination decisions, and must describe its prior authorization and Emergency room utilization management processes to FSSA. When the Contractor conducts a prudent layperson review to determine whether an Emergency medical condition exists, the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field. The Reporting Manual provides information on utilization reporting.

The Contractor's utilization management program shall not be limited to traditional utilization management activities, such as prior authorization. The Contractor must maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures and systems in place to assist utilization management staff to identify instances of over- and under-utilization of Emergency room services, non-emergency medical transportation services and other health care services, identify aberrant provider practice patterns (especially related to Emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams), ensure active participation of a utilization review committee, evaluate efficiency and appropriateness of service delivery, incorporate subcontractor's performance data, facilitate program management and long-term quality and identify critical quality of care issues.

The Contractor's utilization management program must link members to disease management, care management and complex case management, as set forth in Section 5.0. This includes, but is not limited to, integrating prior authorization requests for the identification of members with real-time clinical needs. The Contractor's utilization management program must also encourage health literacy and informed, responsible medical decision making. For example, Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting. Contractors shall also be responsible for

identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

The Contractor shall monitor utilization through retrospective reviews and will identify areas of high and low utilization and identify key reasons for the utilization patterns. The Contractor must identify those members that are high utilizers of Emergency room services and/or other services, including pharmacy, and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, case management or care management services. The Contractor must also use this data to identify additional disease management programs that are needed. Any member with Emergency room utilization must be referred to complex case management or care management. The Contractor may use the Right Choices Program (RCP), as described in Section 5.2.5, in identifying members to refer to disease management, care management or complex case management. The Contractor must identify members with high utilization of controlled substances following the policies and procedures of the Right Choices Program (RCP), as described in Section 5.2.5.

As part of its utilization review, the Contractor shall monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards. The Contractor must develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards.

In order to monitor potential under- or over-utilization of behavioral health services, FSSA requires Contractors to provide separate utilization reports for behavioral health services. The Contractor must particularly monitor use of services for its members with special needs and members with a diagnosis of severe mental illness or substance abuse.

The Contractor's utilization management program must be able to accept prior authorizations, concurrent reviews, retrospective reviews, and appeals of decisions in an electronic format via a web-based system accessible through the Contractor's website.

7.3.1 Authorization of Services and Notices of Actions

Clinical professionals who have appropriate clinical expertise in the treatment of a member's condition or disease must make all decisions to deny a service authorization request (a request for the provision of a service by or on behalf of a member) or to authorize a service in an amount, duration or scope that is less than requested. Only 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 Contractor must not provide incentives to utilization management staff or to providers for denying, limiting or discontinuing medically necessary services. FSSA may audit Contractor denials, appeals and authorization requests. FSSA may waive certain administrative requirements, including prior authorization procedures, to the extent that such waivers are allowed by law and are consistent with policy objectives. The Contractor may be required to comply with such waivers and will be provided with prior notice by FSSA. If the Contractor delegates some or all of its prior authorization function to subcontractors, the Contractor must conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures and state and federal law.

Providers must be able to submit prior authorization requests online and the Contractor must accept the universal prior authorization forms established by the State with no additional information required. The Contractor shall promote submission of prior authorizations online in an electronic format that utilizes automation and built in system logic (e.g., member information pre-population, smart editing to reduce errors, and real-

time verification of whether a service requires authorization, etc.) to reduce administrative burden on providers.

As part of the utilization management function, the Contractor must facilitate provider requests for authorization for primary and preventive care services and must assist providers in providing appropriate referrals for specialty services by locating resources for appropriate referral. In accordance with federal regulations, the process for authorization of services must comply with the following requirements:

- *Second Opinions*: In accordance with 42 CFR 438.206(b)(3), the Contractor must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a provider who is qualified to give a second opinion, the Contractor must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

- *Special Needs*: In accordance with 42 CFR 438.208(c), the Contractor must allow members with special needs, who are determined to need a course of treatment or regular care monitoring, to directly access a specialist for treatment via an established mechanism such as a standing referral from the member's PMP, if applicable, or an approved number of visits. Treatment provided by the specialist must be appropriate for the member's condition and identified needs.

- *Women's Health*: In accordance with 42 CFR 438.206(b)(2), the Contractor must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist. The Contractor must have an established mechanism to permit a female member direct access such as a standing referral from the member's PMP, if applicable, or an approved number of visits. The Contractor may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

The Contractor must track all prior authorization requests in their IT system. All notes in the Contractor's prior authorization tracking system must be signed by clinical staff and include the appropriate suffix (e.g., RN, MD, etc.). For prior authorization approvals, the Contractor shall provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the Contractor's IT system: (a) name of requester; (b) title of requester; (c) date and time of request; and (d) prior authorization number.

For all denials of prior authorization requests, the Contractor shall maintain a record of the following information, at a minimum, in the Contractor's IT system: (a) name of caller; (b) title of caller; (c) date and time of call; (d) clinical synopsis, which shall be include timeframe of illness or condition, diagnosis, and treatment plan; and (e) clinical guideline(s) or other rational supporting the denial (e.g., insufficient documentation).

The Contractor must provide a written notice to the member and provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404. The notice to members must be provided at a fifth-grade reading level. The notice must be given within the timeframes described in the following paragraphs and 42 CFR 438.404(c), specifically:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR 431.211, 431.213, and 431.214.

- For denial of payment, at the time of any action affecting the claim.

- For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 CFR 438.210(d)(1).

- If the Contractor extends the timeframe in accordance with 42 CFR 438.210(d)(1), it must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

- For service authorization decisions not reached within the timeframes specified in 42 CFR 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

The notification letters used by the Contractor must be approved by FSSA prior to use and clearly explain the following:

- The qualifications of the reviewer;

- The guidelines used and reason for denial or approval;

- The action the Contractor or its contractor has taken or intends to take;

- The reasons for the action;

- The member's right to file an appeal with the Contractor and the process for doing so;

- After the member has exhausted the Contractor's appeal process, the notice must contain the member's right to request an FSSA Fair Hearing and the process for doing so;

- Circumstances under which expedited resolution is available and how to request it; and

- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services; and

- The provider's right for a peer to peer utilization review conversation with the reviewer and timeline for requesting the peer to peer review.

Unless otherwise provided in 405 IAC 5-3-14, the Contractor must notify members of standard authorization decisions as expeditiously as required by the member's health condition, not to exceed seven (7) calendar days after the request for services. An extension of up to fourteen (14) calendar days is permitted if the member or provider requests an extension or if the Contractor justifies to FSSA a need for more information and explains how the extension is in the member's best interest. The Contractor will be required to provide its justification to FSSA upon request. Extensions require written notice to the member and must include the reason for the extension and the member's right to file a grievance.

Unless otherwise provided in 405 IAC 5-3-14, if the Contractor fails to respond to a member's prior authorization request within seven (7) calendar days of receiving all necessary documentation, the authorization is deemed to be granted.

For situations in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. The Contractor may extend the seventy-two (72) hours by up to fourteen (14) calendar days if the member requests an extension or the Contractor justifies a need for additional information and how the extension is in the best interest of the member. The Contractor will be required to provide its justification to FSSA upon request.

The Contractor must notify members in writing of decisions to terminate, suspend or reduce previously authorized covered services at least ten (10) business days before the date of action, with the following exceptions:

- Notice is shortened to five (5) business 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 in the event of:
    - The death of a member;
    - The Contractor's receipt of a signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (the member must understand the result of supplying this information);
    - The member's admission to an institution and consequential ineligibility for further services;
    - The member's address is unknown and mail directed to him/her has no forwarding address;
    - The member's acceptance for Medicaid services by another local jurisdiction;
    - The member's physician prescribes the change in the level of medical care;
    - An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions; or
    - The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs or a member has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse actions for nursing facility transfers).

7.3.2 Objection on Moral or Religious Grounds

If the Contractor elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows, in accordance with 42 CFR 438.102(b):

- To FSSA with its response to the RFP;
- To FSSA if it adopts the policy during the term of the Contract;
- To potential members before and during enrollment; and
- To members within ninety (90) calendar days after adopting the policy with respect to any particular service, but at least thirty (30) calendar days prior to the effective date.

7.3.3 Utilization Management Committee

The Contractor must have a utilization management committee directed by the Contractor's Medical Director. The committee is responsible for:

- Monitoring providers' requests for rendering health care services to its members;
- Monitoring the medical appropriateness and necessity of health care services provided to its members;
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed;
- Writing policies and procedures for utilization management that conform to industry standards including methods, timelines and individuals responsible for completing each task; and
- Confirming the Contractor has an effective mechanism in place for a plan provider or Contractor representative to respond within one (1) hour to all Emergency room providers twenty-four (24)-hours-a-day, seven (7)-days-a-week:
  - After the Contractor's member's initial Emergency room screening; and,
  - After the Contractor's member has been stabilized and the Emergency room provider believes continued treatment is necessary to maintain stabilization.

7.4 Program Integrity

The Indiana Office of the Attorney General, Medicaid Fraud Control Unit is the state agency responsible for the investigation of provider fraud in the Indiana Medicaid program. The OMPP Program Integrity Section (OMPP PI), is responsible for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of Medicaid-eligible beneficiaries, identifying and recovering Medicaid waste and abuse, and referring cases of suspected fraud to the MFCU for investigation. The FSSA Bureau of Investigations evaluates and investigates reports of suspected fraud by recipients of assistance programs and both government and contract employees.

The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting, including business transaction disclosure reporting (42 CFR 455.104) and shall further provide any additional information necessary for the FSSA to perform exclusion status checks pursuant to 42 CFR 455.436. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and the terms of this Contract, including at the time of initial contracting, contract renewal, at any time there is a

change to any of the information on the disclosure form, at least once every three (3) years, and at any time upon request.

The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Where the excluded individual is the provider of services or an owner of the provider, all amounts paid to the provider shall be refunded as prescribed in section 7.4 Program Integrity Overpayment Recovery.

The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities. Staffing levels, at a minimum, will be equal to one full-time staff member for every 100,000 members in addition to the Special Investigation Unit Manager and the Compliance Director. The Contractor shall meet this staffing requirement with staff geographically located in Indiana.

The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. The Contractor shall also provide all documentation and information requested by OMPP PI Section or required under this section and its subsections in the form and manner mandated by the OMPP PI Section.

7.4.1 Program Integrity Plan

Pursuant to 42 CFR 438.608, which sets program integrity requirements, the Contractor must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The Program Integrity Plan shall serve as Contractor's compliance plan. The Program Integrity Plan shall be submitted annually and upon request by the OMPP Program Integrity (PI) Section, updated quarterly, or more frequently if required by the OMPP PI Section, and be submitted to OMPP. The PI Plan and/or updates to the PI Plan shall be submitted to OMPP through the reporting process fifteen (15) business days prior to the scheduled meetings discussing the plan. The PI Plan shall include provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of Contractor's providers, vendors, and subcontractors (including but not limited to Pharmacy Benefits Managers) and Contractor itself, including:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.

- The designation of a Special Investigation Unit Manager, a Compliance Officer and a Compliance Committee. The Plan should document that the Compliance Officer and SIU Manager shall meet with the OMPP PI Section at a minimum of quarterly intervals and as directed by the OMPP PI Section.

- The type and frequency of training and education for the Special Investigation Unit Manager, Compliance Officer, and the organization's employees who will be provided to detect fraud. Training must be annual and address the False Claims Act, Indiana laws and requirements governing Medicaid reimbursement and the utilization of services – particularly changes in rules, and other Federal and state laws governing Medicaid provider participation and payment as directed by CMS and FSSA.

- A risk assessment of the Contractor's various fraud and abuse program integrity processes. A risk assessment shall also be submitted on an 'as needed' basis or at

a minimum of every 6 months. This assessment shall also include a listing of the Contractor's top three (3) vulnerable areas and shall outline action plans mitigating such risks.

- An organizational chart and communication plan highlighting lines of communication between the Special Investigation Unit Manager, the Compliance Officer and the organization's employees.
- Provision for internal monitoring and auditing.
- Procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this contract.
- A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:
    - A list of automated pre-payment claims edits.
    - A list of automated post-payment claims edits.
    - A list of types of desk audits on post-processing review of claims.
    - A list of reports for provider profiling and credentialing used to aid program and payment integrity reviews.
    - A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.
    - A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials.
    - A list of references in provider and member material regarding fraud and abuse referrals.
    - A list of provisions for the confidential reporting of PI Plan violations to the designated person.
    - A list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports.
- Provisions ensuring that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.
- 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 Section and pursuant to section 7.4.3 below.
- Assurances that no individual who reports Contractor's potential violations or suspected fraud and abuse is retaliated against.

- Policies and procedures for conducting both announced and unannounced site visits and field audits to providers defined as high risk (including but not limited to providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

- Provisions for prompt response to detected offenses, and for development of corrective action initiatives.

- Program integrity-related goals, objectives and planned activities for the upcoming year.

7.4.2 Program Integrity Operations

The Contractor shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard Medicaid funds against improper payments and unnecessary or inappropriate use of Medicaid. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected waste, fraud and abuse activities. Contractor shall have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud and abuse issues of Contractor's providers, vendors, and subcontractors (including Pharmacy Benefits Managers, Dental Benefits Managers, Transportation Brokers, and Contractor itself). Contractor is required to conduct and maintain at a minimum the following operations and capabilities on a routine basis and as necessary for the effective reduction of Medicaid waste, fraud and abuse.

- The Special Investigation Unit within the Contractor's structure shall have the ability to make referrals to the OMPP PI Section, and accept referrals from a variety of sources including but not limited to: directly from providers (either provider self-referrals or from other providers), members, law enforcement, and government agencies. The Contractor shall also have effective procedures for timely reviewing, investigating, and processing such referrals.

- The Contractor will suspend all payments to a provider after the Agency determines that there is a credible allegation of fraud and has provided the Contractor with written notice of a payment suspension. The Contractor shall implement measures to assure that payment suspensions can be instituted and lifted quickly following receipt of notification.

- Data mining, analytics, and predictive modeling for the identification of potential overpayments and aberrant payments and providers warranting further review and investigation.

- Provider profiling and peer comparisons of all of Contractor's provider types and specialties, at a minimum annually, to identify aberrant service and billing patterns warranting further review/audit.

- Onsite Audit capability and protocols identifying how and when the Special Investigation Unit shall conduct such onsite audits of providers.

- Medical claim audit capabilities sufficient to enable the Contractor's 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 and provider type.

- Member service utilization analytics to identify members that may be abusing services. Contractor shall submit to FSSA for approval the criteria utilized for its

review of its members and the referral of members to the Right Choices Program.

7.4.3 Program Integrity Reporting

The Contractor shall cooperate with all appropriate state and federal agencies, including the Indiana MFCU and the OMPP PI Section, in investigating fraud and abuse. The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21). Contractor shall provide the identified routine program integrity reports to OMPP and the OMPP PI Section.

- Upon conclusion of its audit/investigation, the Contractor shall immediately report all suspected or confirmed instances of waste, fraud and abuse to the OMPP and the OMPP PI Section.

- The Contractor shall use the Reporting Forms provided by the OMPP for all such reporting or such other form as may be deemed satisfactory.

- The Contractor shall be subject to non-compliance remedies under this Contract identified in Exhibit 2 Contract Compliance and Pay for Outcomes for willful failure to report fraud and abuse by providers, Medicaid beneficiaries/members, or applicants to the OMPP PI Section as appropriate.

- Confirmed or suspected cases of waste, fraud and abuse may be discussed at monthly coordination meetings with all of the managed care entities, the OMPP PI Section, and the Indiana MFCU.

The Contractor shall promptly perform a preliminary investigation of all incidents of suspected or confirmed fraud, waste, and abuse, unless prior written approval is obtained from the OMPP PI Section. The Contractor shall promptly report suspected or confirmed fraud and abuse to OMPP or another agency that has been designated by OMPP to receive the report. The Contractor shall not take any of the following actions as they specifically relate to Indiana claims:

- Contact the subject of the investigation about any matters related to the investigation;

- Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

The Contractor shall promptly provide the results of its preliminary investigation to the OMPP PI Section or to another agency designated by the OMPP PI Section.
The Contractor shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

The Contractor shall suspend all payments to a provider after OMPP determines that there is a credible allegation of fraud and has provided the Contractor with a written notice of a payment suspension

On a routine State approved basis, the Contractor shall submit to OMPP reports on identified program-integrity activities. These include, a monthly report identifying current

program integrity related audit/investigation activity along with identification of the approximate range of dollars involved, and the final overpayment identified; and a quarterly report identifying provider payment suspensions the Contractor has implemented, and providers that the Contractor has placed onto prepayment review. The Contractor shall also submit additional reports as directed by the OMPP PI Section. The OMPP PI Section shall review and approve, approve with modifications, or reject reports and specify the grounds for rejection.

In accordance with 42 CFR 438.608(d)(3), the Contractor shall report annually to the State on the recoveries of overpayments.

The Contractor shall notify OMPP within one (1) business day upon discovery of a HIPAA or other security breach.

7.4.4 Program Integrity Overpayment Recovery

The Contractor has primary responsibility for the identification of all potential waste, fraud and abuse associated with services and billings generated as a result of this Contract. In cases involving wasteful or abusive provider billing or service practices, including overpayments, identified and recovered by Contractor, the Contractor will have policies and procedures in place to fully comply with 42 CFR 438.608. The Contractor 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 Section, OMPP may recover any identified overpayment directly from the provider or may require Contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Section. The OMPP PI Section may also take disciplinary action against any provider identified by Contractor or the OMPP PI Section as engaging in inappropriate or abusive billing or service provision practices.

If a fraud referral from Contractor generates an investigation or corresponding legal action results in a monetary recovery to IHCP, the reporting Contractor will be entitled to share in such recovery following final resolution of the matter, settlement agreement or final court judgment, and following payment of recovered funds to the State of Indiana. The Contractor's share of recovery will be as follows:

- From the recovery, the State, including MFCU, shall retain its costs of pursuing the action, including any costs associated with OMPP PI Section operations associated with the investigation, and its actual documented loss. The State will pay to the Contractor the remainder of the recovery, not to exceed the Contractor's actual documented loss. Actual documented loss of the parties will be determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.

- If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the Contractor about potential settlement. The State may consider the Contractor's preferences or opinions about acceptance, rejection or the terms of a settlement, but they are not binding on the State.

- If final resolution of a matter does not occur until after the Contract has expired, the preceding terms concerning disposition of any recovery and consultation with the

Contractor shall survive expiration of the Contract and remain in effect until final resolution of a matter referred to the MFCU by the Contractor under this section.

If the State makes a recovery from a fraud investigation or corresponding legal action where the Contractor has sustained a documented loss but the case did not result from a referral made by the Contractor, the State shall not be obligated to repay any monies recovered to Contractor, but may do so at its discretion. Funds recovered as a result of a multi-state fraud investigation or litigation, however, will be shared with Contractor as prescribed for funds recovered as a result of Contractor's fraud referral absent extenuating circumstances.

The Contractor is prohibited from the repayment of state-, federally-, or Contractor-recovered funds to any provider when the issues, services or claims upon which the repayment is based meets one or more of the following:

- The funds from the issues, services or claims have been obtained by the State or Federal governments, either by the State directly or as part of a resolution of a state or federal audit, investigation and/or lawsuit, including but not limited to false claims act cases;

- When the issue, services or claims that are the basis of the repayment have been or are currently being investigated by the OMPP PI Section Unit, the Unified Program Integrity Contractor (UPIC), Contractor, Indiana MFCU, or Assistant United State Attorney (AUSA), or are the subject of pending Federal or State litigation.

This prohibition described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The Contractor shall check with the OMPP PI Section before initiating any repayment of any program integrity related funds to ensure that the repayment is permissible.

7.4.5 Auditing Program Integrity Operations

The OMPP PI Section may conduct audits of Contractor's Special Investigation (SI) Unit activities to determine the effectiveness of Contractor's operations. Such audit activities may include conducting interviews of relevant staff, reviewing all documentation and systems used for Special Investigation Unit activities, and reviewing the SI Unit's performance metrics. The OMPP PI Section may issue a corrective action or performance improvement plan and outline timelines for improvement measures. The failure to adhere to operational improvement measures may result in the State's imposing liquidated damages up to the amount of overpayments recovered from Contractor's providers by OMPP PI Section audits for the preceding calendar year, or imposing other non-compliance remedies including liquidated damages as authorized by Contract in Exhibit 2 Contract Compliance and Pay for Outcomes.

7.5 Monitoring and Reporting Foster Children Psychotropic Medication Use

The Contractor shall comply with all State and Federal laws and regulations regarding the management of health care services for children in foster care, including but not limited to the Fostering Connections to Success and Increasing Adoptions Act of 2008 and the Child and Family Services Improvement and Innovation Act of 2011, and any amendments thereto. Further, the Contractor shall provide monitoring and reporting in the manner and timeframe specified by FSSA to ensure compliance with federal reporting requirements on the management and usage of psychotropic medications among foster children.

8.0 Information Technology (IT) Systems

The Contractor must have an Information Technology (IT) systems sufficient to support the Hoosier Care Connect program requirements, and the Contractor must be prepared to submit all required data and reports in the format specified by FSSA. This may include, at the State's discretion, an administrative data extract in a prescribed format outlined in the Reporting Manual. The Contractor must maintain a IT systems with capabilities to provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility in accordance with 42 CFR 438.242, and perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Section. The Contractor's IT Systems must support provider electronic submission of authorization requests, authorization appeals, claims, claim disputes and claim appeals.

In the event the State's technical requirements require amendment during the term of the Contract, the State will work with Contractors in establishing the new technical requirements. The Contractor must be capable of adapting to any new technical requirements established by the State, and the State may require the Contractor to agree in writing to the new requirements. After the Contractor has agreed in writing to a new technical requirement, any Contractor-initiated changes to the requirements shall require FSSA approval and FSSA may require the Contractor to pay for additional costs incurred by the State in implementing the Contractor-initiated change.

The Contractor shall develop processes for development, testing, and promotion of system changes and maintenance. The Contractor shall notify FSSA at least thirty (30) calendar days prior to the installation or implementation of minor software and hardware changes, upgrades, modifications or replacements. The Contractor shall notify FSSA at least (90) calendar days prior to the installation or implementation of major software or hardware changes, upgrades, modifications or replacements. "Major" changes, upgrades, modifications or replacements are those that impact mission critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, encounter data management, and any other processing affecting the Contractor's capability to interface with the State or the State's contractors. The Contractor shall ensure that system changes or system upgrades are accompanied by a plan which includes a timeline, milestones and adequate testing to be completed prior to implementation. The Contractor shall notify and provide such plans to FSSA upon request in the timeframe and manner specified by the State.

The Contractor must have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164). The Contractor's IT systems must support HIPAA Transaction and Code Set requirements for electronic health information data exchange, NPI requirements and Privacy and Security Rule standards. The Contractor's IT plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308);
- Physical safeguards (45 CFR 164.310); and
- Technical safeguards (45 CFR 164.312).

The Contractor must make data available to FSSA and, upon request, to CMS. In accordance with 42 CFR 438, subpart H, the Contractor must submit all data, including encounter claims, under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the Contractor's data. The Reporting Manual will provide an attestation form which must be utilized by the Contractor.

The Contractor must comply with all Indiana Office of Technology (IOT) standards, policies and guidelines, which are available online at http://in.gov/iot/2394.htm. All hardware, software and services provided to or purchased by the State shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d) and IC 4-13.1-3. Any deviation from these architecture requirements must be approved in writing by IOT in advance.

In addition to the IOT policies, the Contractor shall comply with all FSSA Application Security Policies. Any deviation from the policies must be approved in writing from FSSA. Furthermore, Contractors must be willing to accept FSSA's Confidentiality, Security and Privacy of Personal Information contractual terms.

8.1 Testing with the State

The Contractor shall complete various testing with the Indiana Medicaid Management Information System (CoreMMIS) as directed by the State (including but not limited to system integration testing, user acceptance testing, and end-to-end testing). The Contractor shall also comply with testing requirements with any additional systems which require data exchange with the State or its designee, in the timeframe and method determined by the State.

8.1.1 Master Test Plan

Software testing is the process of evaluation to detect differences between given input and expected output. Testing assesses the quality of the product. Software testing is a verification and validation process that should be done during the development process.

The Contractor's Master Test Plan should be fully inclusive of the testing phases listed below. Any deviations from this list of phases (additions or deletions) will need to be explained and justified in the State approved Contractor's Master Test Plan.

1. Unit Testing (UT)

   Defined as testing conducted on individual units (components) of an integrated system, designed to validate that each unit performs as designed.

2. System Integration Testing (SIT)

   Defined as testing conducted on a complete, integrated system to evaluate the system's compliance with its specified requirement.

3. External Contractor and/or Partner Testing

   Defined as independent testing to demonstrate that the applicable phase of the system and the system as installed conforms to the application system specifications.

4. User Acceptance Testing (UAT)

   Defined as acceptance testing often done by the customer to ensure that the delivered product meets the requirements and works as the customer expected. The Contractor is required to provide 'proof of life' (aka 'proof of concept') demonstrations for all systems prior to UAT.

5. End-to-End (E2E) Testing

   Defined as testing that the flow of an application is performing as designed from start to finish to identify system dependencies and ensure that the right information is passed between various system components and systems.

6. Regression Testing

   Defined as testing after modification of a system, component, or a group of related units to ensure that the modification is working correctly and is not damaging or imposing other modules to produce unexpected results.

7. Stress / Volumetric Testing

   Defined as testing to evaluate how the application or system behaves under unfavorable conditions and how it recovers when going back to normal usage. Stress Testing is conducted at upper and beyond limits of the specifications.

8. Security Testing

   Contractor may be subject to either the creation of, or full cooperation with, Security Assessment or testing as prescribed by state. This may include Penetration Testing or SOC-1 audits.

The State requires the following specific criteria to be formally adopted, included, or executed as part of the contractor's holistic testing plan:

1. Each Test Plan shall include, but not be limited to, the following:

   a. Testing Strategy, including dates and participants

   b. Test Scenarios and Cases

   c. Full Requirement Tracing

   d. Input Data

   e. Expected Results

   f. Actual Results

   g. Status

   h. Secondary Result Validation

2. Provide for at least a month between testing completion and Go Live.

3. Access must be directly provided to the correct testing environments at no cost to any participant internal or external to the contractor.

4. Participate in test phases including other parties (such as Contractor or User Acceptance testing) not just by providing access, but by developing test plans and scenarios for these phases as well, and providing the required input data and unique configurations to support all internal and external test cases.

5. Cooperation and collaboration with all contractors, stakeholders and testing partners is required by the State to ensure each test phase is successful. This collaboration shall extend to test phases run by other partners external to those managed by the Contractor in order to ensure the success of the effort overall.

Furthermore, the State requires that contractors adhere to its criteria for and definition of defects listed below in Table 1, their severities, and the defined actions required by Severity. The State has unilateral authority to assign or change a defect level:

Table 1, Defect Severity Definitions and Required Actions

Severity	Definition / Criteria for Assignment	Required Schedule / Action to Resolve
1	Catastrophic - Functionality causes critical impact / system failure. Any defect that causes major system impacts or interface issues and is not acceptable for production. A serious deviation from requirements which prohibits the stakeholder from accurately completing a major piece of functionality.	Any Severity 1 defects must be resolved, re-tested and the fix confirmed prior to implementation.
2	Major - Major functions are/would be disabled; no workaround exists.	Any Severity 2 defects must be resolved, re-tested and the fix confirmed prior to implementation
3	Medium - Major functions are/would be disabled; workaround available and acceptable to the State. A minor deviation from requirements which prohibits the stakeholder from completing a minor piece of functionality accurately and there may or may not be an appropriate workaround acceptable to the State. Note: The State may make determinations that certain errors classified as "Minor deviations" are to be corrected before the system is ready for production.	Any Severity 3 defects must have a state-approved workaround, including detailed operating procedures for the intervention and an implementation plan for the automated fix. Final fix must be re-tested, implemented, and confirmed within 90 days of Go Live
4	Minor – minor functions are/would be disabled	Any severity 4 defects must be resolved, re-tested, implemented and confirmed within 180 days of Go Live
5	Cosmetic – a deviation from requirements, which does not prohibit processing of a piece of functionality, or indicates an internal issue that is not considered a defect in the system, but requires attention to ensure quality of the system.	Any severity 5 defects must be resolved, re-tested, implemented and confirmed within 365 days of Go Live

8.2 Business Contingency and Disaster Recovery Plans

IT system contingency planning shall be developed in accordance with the requirements of this Section and with 45 CFR 164.308. The Contractor's business contingency and disaster recovery plan documents (Contingency Plans) shall include: data backup plans, disaster recovery plans and emergency mode of operation plans. Application and data criticality analysis and testing and revisions procedures must also be addressed within the Contingency Plans. The Contractor is responsible for executing all activities needed to recover and restore operation of IT systems, data and software at an existing or alternate location under emergency conditions within twenty-four (24) hours of identification of a disaster. The Contractor must protect against hardware, software and human error. The Contractor must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. The Contractor must maintain full and complete back-up copies of data and software, and must back up on tape or optical disk and store its data in an off-site location approved by FSSA.

For purposes of this Section, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Contractor's or its subcontracting entities' IT systems or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. Disasters may include natural disasters, human error, computer virus or malfunctioning hardware or electrical supply. The Contractor must take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status.

The Contractor shall notify FSSA, at minimum, within two (2) hours of discovery of a disaster or other disruptions in its normal business operations. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, encounter data management, and any other processing affecting the Contractor's capability to interface with the State or the State's contractors. Depending on the anticipated length of disruption, FSSA, in its discretion, may require the Contractor to provide FSSA a detailed plan for resuming operations. In the event of a catastrophic or natural disaster (including, but not limited to, fire, flood, earthquake, storm, hurricane, war, invasion, act of foreign enemies, or terrorist activities), the Contractor shall resume normal business functions at the earliest possible time, not to exceed thirty (30) calendar days. If deemed appropriate by the State, the Contractor shall coordinate with the State fiscal agent to restore the processing of claims by Indiana *Core*MMIS if the claims processing capacity cannot be restored within the Contractor's system. In the event of other disasters or system unavailability caused by the failure of systems and technologies within the Contractor's span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply), the Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten (10) calendar days.

The Contractor'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 weekly back-up and a daily back-up that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations and user documentation.
- Demonstrating an ability to meet data back-up requirements by submitting and maintaining data backup plans, as part of its Contingency Plans that address:
    - Checkpoint and restart capabilities and procedures;
    - Retention and storage of back-up files and software;
    - Hardware back-up for the servers;
    - Hardware back-up for data entry equipment; and
    - Network back-up for telecommunications.
- Developing coordination methods for disaster recovery activities with FSSA and its contractors to ensure continuous eligibility, enrollment and delivery of services.
- Providing the State with business resumption documents, reviewed and updated at least annually, such as:

- Disaster Recovery Plans;
- Business Continuity and Contingency Plans;
- Facility Plans; and
- Other related documents as identified by the State.

- Having in place a fully tested IT business continuity/disaster recovery plan (ITBCP) that, at minimum, meets the requirements of NIST SP800-34. The ITBCP shall be submitted to the State within ninety (90) calendar days of Contract award with, at minimum, annual updates thereafter. The Contractor shall make reasonable updates and changes to its ITBCP as requested from time-to-time by the State or as otherwise may be required by applicable federal or state laws and regulations.

- Coordinating the ITBCP with FSSA's IT business continuity/disaster recovery plans, including other State solutions with which the Contractor's system interfaces, to assure appropriate, complete and timely recovery. The Contractor shall coordinate the development, updating and testing of its ITBCP with the State in the State's development, updating, and testing of its Continuity of Operations Plan (COOP), as required by State policy and Homeland Security Presidential Directive (HSPD) 20.

- The ITBCP will be based upon recovery point and recovery time objectives agreed upon between the Contractor and FSSA and on a comprehensive assessment of threat and risk performed by the Contractor. The threat and risk assessment shall be updated no less than annually by the Contractor to reflect technological, Contractor business and State business operation changes and other appropriate factors.

- The Contractor shall test the ITBCP no less than annually, with such testing being comprehensive in nature and scope assuring point-to-point testing in meeting the agreed upon recovery point and recovery time objectives. The Contractor shall perform the first test within ninety (90) calendar days of Contract award. The Contractor shall provide the State with an annual report regarding the testing and updating of the ITBCP, including the results of the annual test, including failure points and corrective action plans. The first report shall be due within thirty (30) calendar days of the Contractor's completion of the first test.

8.3 Member Enrollment Data Exchange

The Contractor is responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member. The Contractor must reconcile its eligibility and capitation records at least monthly. If the Contractor discovers a discrepancy in eligibility or capitation information, the Contractor must notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records. The Contractor must return any capitation overpayments to FSSA within forty-five (45) calendar days of discovering the discrepancy. If the Contractor receives either enrollment information or capitation for a member, the Contractor is financially responsible for the member.

The Contractor must accept enrollment data in electronic format, currently via secure file transfer protocol (FTP), as directed by FSSA and as detailed in the Indiana Health Coverage Program Companion Guide- 834 Benefit Enrollment and Maintenance (834 Companion Guide), which shall be updated by FSSA prior to the Contract effective date to include Hoosier Care Connect protocols. FSSA reserves the right to amend the 834 Companion

Guide during the Contract term. The current 834 Companion Guide is provided in the Bidders' Library as an example only. The Contractor is responsible for loading the eligibility information into its claims system within five (5) calendar days of receipt. In addition, the Contractor's IT systems must accommodate the State's member identification number (MID) for each member and the master client index (MCI).

8.4 Provider Network Data

The Contractor must submit provider network information to the State fiscal agent via IHCP Provider Healthcare Portal. The Contractor shall keep provider enrollment and disenrollment information up-to-date. The Contractor shall enter updates into Provider Healthcare Portal no less frequently than on the first (1st) and fifteenth (15th) day of each month, or as otherwise directed by the State. More information regarding provider network data will be available in the Hoosier Care Connect Policies and Procedures Manual. The Contractor must provide single sign-on for providers to access the Provider Healthcare Portal.

8.5 Claims Processing

8.5.1 Claims Processing Capabilities

The Contractor must demonstrate and maintain the capability to process and pay provider claims for services rendered to the Contractor's members, in compliance with HIPAA, including NPI. The Contractor must be able to price specific procedures or encounters (depending on the agreement between the provider(s) and the Contractor) and to maintain detailed records of remittances to providers. In accordance with Section 2.3, FSSA must pre-approve the Contractor's delegation of any claims processing function to a subcontractor, such as but not limited to a Dental Benefits Manager or Transportation Broker. The Contractor must notify FSSA and secure FSSA's approval of any change to sub-contracting arrangements for claims processing. The Contractor shall use all applicable National Correct Coding Initiative (NCCI) edits in the processing of claims, except where State policy requires payment methodologies that contradict with NCCI edits. The Contractor shall use code sets and standards established and maintained by FSSA

The Contractor must develop policies and procedures to monitor claims adjudication accuracy and must submit its policies and procedures for monitoring its claims adjudication accuracy to FSSA for review and approval.

The out-of-network provider filing limit for submission of claims to the Contractor is six (6) months from the date of service. This conforms to the filing limit under the Medicaid state plan (42 CFR 447.45(d)(4)). The in-network provider filing limit is established in the Contractor's provider agreements pursuant to the guidelines set forth in Section 6.5, which generally require in-network providers to submit claims within ninety (90) days from the date of service. Timely filing limits are automatically waived in the instances of eligibility updates/retroactivity, agency error, or any other condition established by FSSA in rule or policy. The Contractor's IT systems must allow for the bypassing of timely filing limits or indication of alleged waiver for these established conditions that does not solely rely on the appeals or grievance processes outlined in this Contract.

The Contractor 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.

The Contractor's in-network provider claim dispute process must adhere to the same rules laid out for out-of-network providers in 405 IAC 1-1.6-1.

8.5.2 Compliance with State and Federal Claims Processing Regulations

The Contractor must have a claims processing system to support electronic claims submission for both in- and out-of-network providers. The Contractor's system must process all claim types such as professional, institutional and pharmacy claims. The Contractor must comply with the claims processing standards and confidentiality standards under IC 12-15-13-1.6 and IC 12-15-13-1.7, and any applicable federal regulations, including HIPAA regulations related to the confidentiality and submission requirements for protected health information (PHI). The Contractor must ensure that communication with providers, particularly out-of-network providers, and submission requirements are efficient and not burdensome for any providers. The Contractor is prohibited from requiring out-of-network providers to establish a Contractor-specific provider number in order to receive payment for claims submitted. The Contractor shall not require providers to bill using any number other than the FSSA assigned Member ID number.

8.5.3 Claims Payment Timelines

The Contractor must pay providers for covered medically necessary services rendered to the Contractor's members in accordance with the standards set forth in IC 12-15-13-1.6 and IC 12-15-13-1.7, unless the Contractor and provider agree to an alternate payment schedule and method. The Contractor must also abide by the specifications of 42 CFR 447.45(d)(5) and (d)(6), which require the Contractor to ensure that the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

The Contractor must pay or deny electronically filed clean claims within twenty-one (21) calendar days of receipt. A "clean claim" is one in which all information required for processing the claim is present. The Contractor must pay or deny clean paper claims within thirty (30) calendar days of receipt. If the Contractor fails to pay or deny a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, the Contractor must also pay the provider interest at the rate set forth in IC 12-15-21-3(7)(A). The Contractor must pay interest on all clean claims paid late (i.e., in- or out-of-network claims) for which the Contractor is responsible, unless the Contractor and provider have made alternate written payment arrangements.

The Contractor shall meet the requirements set forth in IC 27-13-36.2-3 and notify providers of deficiencies in claims within the set timelines in State statute.

All providers must be offered on their provider agreement the option to select Electronic Fund Transfer (EFT) for provider payments. The Contractor shall develop a plan to issue payments predominantly via EFT and submit to the State for approval.

FSSA reserves the right to perform a random sample audit of all claims, and expects the Contractor to fully comply with the requirements of the audit and provide all requested documentation, including provider claims and encounters submissions.

8.5.4 Rate Update Timeliness

The Contractor shall have policies and procedures in place to load new fee schedules and fee schedule updates from FSSA into their claims processing systems. The Contractor shall update fee schedules within thirty (30) days of the fee schedule effective date or date of notice of the fee schedule change, whichever is later. Failure to adhere to this requirement will result in corrective action, as described in Exhibit 2 Contract Compliance and Pay for Outcomes.

8.5.5 Medicaid National Correct Coding Initiative (NCCI)

Disclosure of information contained in the Medicaid National Correct Coding Initiative (NCCI) files shall be limited to only those responsible for the implementation of the quarterly State Medicaid NCCI edit files. Disclosure shall not be made prior to the start of the new calendar quarter.

After the start of the new calendar quarter, the Contractor may disclose only non-confidential information contained in the Medicaid NCCI edit files that is also available to the general public found on the Medicaid NCCI webpage. The Contractor agrees to use any non-public information from the quarterly State Medicaid NCCI edit files only for any business purposes directly related to the implementation of the Medicaid NCCI methodologies in the Indiana.

New, revised, or deleted Medicaid NCCI edits shall not be published or otherwise shared by the Contractor with individuals, medical societies, or any other entities unless they were a Contracted Party prior to the posting of the Medicaid NCCI edits on the Medicaid NCCI webpage. Implementation of new, revised, or deleted Medicaid NCCI edits shall not occur prior to the first day of the calendar quarter. Only FSSA has the discretion to release additional information for selected individual edits or limited ranges of edits from the NCCI files shared with the Contractor. FSSA will impose penalties, up to and including loss of Contract, for violations of this confidentiality agreement relating to use of the Medicaid NCCI files.

8.6 Encounter Data Submission

The Contractor shall have policies, procedures and mechanisms in place to support the encounter data reporting process described below and in the State fiscal agent's Companion Guides. The Contractor shall strictly adhere to the standards set forth in the State fiscal agent's Companion Guides, as may be amended from time to time, such as the file structure and content definitions (including any content definitions as may further be interpreted or defined by FSSA). The quality of Contractor's encounter data submissions shall be subject to audit and validation. Contractor shall fully comply with all such audit and validation activities including, but not limited to, attending meetings, providing background information on encounter data submissions, providing access to systems, records, and personnel that can assist auditors with their work, and timely responding to all information requests from the State or its auditors.

The Contractor technical meetings with FSSA and the Fiscal Agent provides a forum for Contractor technical support staff to participate in the development of the data exchange process and ask questions related to data exchange issues, including encounter data transmission and reporting issues. The Contractor shall report any problems it is experiencing with encounter data submissions and reporting at this monthly meeting and to its designated FSSA Policy Analyst.

8.6.1 Definition and Uses of Encounter Data

The Contractor shall submit an encounter claim to the State fiscal agent or its designee for every service rendered to a member for which the Contractor either paid or denied reimbursement. Encounter data provides reports of individual patient encounters with the Contractor's health care network. These claims contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts and rendering providers' identification numbers and other detailed claims data required for quality improvement monitoring and utilization analysis. The State will use the encounter data to make tactical and strategic decisions related to the Hoosier Care Connect program and to the Contract.

The State shall primarily use the encounter data to make tactical and strategic decisions related to the Hoosier Care Connect program and to the Contract. The State shall primarily use encounter data to calculate the Contractor's future capitation rates, with alternative data sources utilized as appropriate to meet actuarial and federal standards. Encounter data will also be used to calculate incentive payments to the Contractor, monitor quality and to assess the Contractor's Contract compliance. See Exhibit 2 for a schedule of liquidated damages that FSSA will assess for non-compliance with encounter data submission requirements.

8.6.2 Reporting Format and Batch Submission Schedule

The Contractor shall submit institutional, pharmacy, dental, vision, transportation and other professional encounter claims in an electronic format that adheres to the data specifications in the 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 Contractor'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 (i.e., original, void or replacement) is also required, in the form designated by FSSA.

The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week, or other date and time as specified by the State. FSSA will use an overall average of calendar month submissions to assess compliance with this encounter claim submission requirement. The State shall require the Contractor to submit a corrective action plan and shall assess liquidated damages for failure to comply with the encounter claims submission requirements. See Exhibit 2 for a schedule of liquidated damages FSSA shall assess for non-compliance with this requirement. Only data and information accepted by the data warehouse by June 30 shall be considered for the next year's capitation rate adjustments. For example, only encounters and information accepted by June 30, 2022 would be considered for 2023 rate setting purposes.

8.6.3 Encounter Claims Quality

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

The Contractor shall comply with the following requirements:

- Timeliness of Contractor's Encounter Claims Submission: The Contractor shall submit ninety eight percent (98%) of adjudicated claims within fourteen (14) calendar days of adjudication. The Contractor shall submit void/replacement claims within two (2) years from the date of service.

- Compliance with Pre-cycle Edits: The State or its designee will assess each encounter claim for compliance with pre-cycle edits. The Contractor must correct and resubmit any encounter claims that do not pass the pre-cycle edits.

- Accuracy of Encounter Claims Detail: The Contractor shall demonstrate that it implements policies and procedures to ensure that encounter claims submissions are accurate; that is, that all encounter claims detail being submitted accurately represents the services provided and that the claims are accurately adjudicated according to the Contractor's internal standards and all state and federal requirements. FSSA shall have the right to monitor Contractor encounter claims for accuracy against the Contractor's internal criteria and its level of adjudication accuracy. FSSA shall regularly monitor the Contractor's accuracy by reviewing the Contractor's compliance with its internal policies and procedures for ensuring accurate encounter claims submissions and by performing a random sample audit of all claims. FSSA expects the Contractor to fully comply with the requirements of the review and audit and to provide all requested documentation, including provider and encounter claims submissions and medical records. FSSA shall require the Contractor to submit a corrective action plan and will require non-compliance remedies for the Contractor's failure to comply with encounter claims accuracy reporting standards.

- Completeness of Encounter Claims Data: The Contractor shall have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers, i.e., for every service provided, providers shall submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions, including National Drug Codes as applicable. The Contractor shall also have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided.

The Contractor shall adhere to CMS encounter submission requirements under 42 CFR 438.242. Encounters shall include allowed amounts and paid amounts. Subcontractor administrative costs must be excluded from paid amounts.

As part of its annual encounter claims work plan, the Contractor shall demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance. FSSA may require the Contractor to demonstrate, through report or audit, that this monitoring system is in place and that the Contractor is regularly monitoring the completeness of claims and encounter data and ensuring that the Contractor is meeting FSSA's completeness requirements.

FSSA shall require the Contractor to submit a corrective action plan and will require non-compliance remedies for the Contractor's failure to comply with encounter claims completeness reporting standards, as identified in the Encounter Data Quality Validation template.

8.7 Third Party Liability (TPL) Issues

8.7.1 Coordination of Benefits

If a member is also enrolled in or covered by another insurer (including a parent organization or other health plan affiliated with the Contractor), the Contractor is fully responsible for coordinating benefits so as to maximize the utilization of third-party coverage. The Contractor must share information regarding its members, especially those with special health care needs, with other payers as specified by FSSA and in accordance with 42 CFR 438.208(b). In the process of coordinating care, the Contractor must protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164.

The Contractor is responsible for payment of the member's coinsurance, deductibles,

copayments and other cost-sharing expenses, but the Contractor's total liability must not exceed what the Contractor would have paid in the absence of TPL, after subtracting the amount paid by the primary payer. The Contractor must coordinate benefits and payments with the other insurer for service authorized by the Contractor, but provided outside the Contractor's plan. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the member or provider of service by the Contractor must not prevent or unduly delay a member from receiving medically necessary services. The Contractor remains responsible for the costs incurred by the member with respect to care and services which are included in the Contractor's capitation rate, but which are not covered or payable under the other insurer's plan.

The Contractor must have a signed Coordination of Benefits Agreement (COBA) with CMS and participate in the automated crossover claim process administered by Medicare.

In accordance with IC 12-15-8 and 405 IAC 1-1-15, FSSA has a lien upon any money payable by any third party who is or may be liable for the medical expenses of a Medicaid recipient when Medicaid provides medical assistance. The Contractor may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

If the member's primary insurer is a commercial HMO and the Contractor cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the Contractor's rules, the Contractor may submit to the Enrollment Broker a written request for disenrollment. The request must provide the specific description of the conflicts and explain why benefits cannot be coordinated. The Enrollment Broker will consult with FSSA and the request for disenrollment will be considered and acted upon accordingly.

8.7.2 Collection and Reporting

The Contractor will be responsible for identifying, collecting and reporting TPL coverage and collection information to the State. As TPL information is a component of capitation rate development, the Contractor must maintain records regarding TPL collections and report these collections to FSSA in a timeframe and format determined by FSSA. The Contractor will retain all TPL collections made on behalf of its members.

8.7.3 Cost Avoidance

The Contractor's TPL responsibilities include cost avoidance. When the Contractor is aware of other insurance coverage prior to paying for a health care service for a member, it should avoid payment by rejecting a provider's claim and direct that the provider first submits the claim to the appropriate third party. The Contractor will be allowed to keep all of the costs it recovers from the third party, as set forth in Section 8.7.2 above.

When the Contractor has identified members who have newly discovered health insurance, members who have changed coverage or members who have casualty insurance coverage, the Contractor will provide the State and its fiscal agent the following information:

- Member name/MID number/Social Security number;

- Carrier name/address/phone number/contact person;
- Policyholder name/address/Social Security number/relationship to member; and
- Policy number/effective date/coverage type.

If insurance coverage information is not available, or if one of the exceptions to the cost avoidance rule discussed in this section applies, then the Contractor must make the payment and make a claim against the third party, if it is determined that the third party is or may be liable. The Contractor must ensure that its cost avoidance efforts do not prevent a member from receiving medically necessary services in a timely manner.

8.7.4 Retroactive Medicare Coverage

Medicare enrollees are excluded from Hoosier Care Connect enrollment. However, members may become retroactively Medicare eligible. When this occurs, the Contractor shall recover medical expenses payable by Medicare for the months of retroactive Medicare eligibility. The State will recoup the capitation rate paid for months with retroactive Medicare eligibility and pay a reduced dual-eligible capitation rate.

8.7.5 Cost Avoidance Exceptions

Cost avoidance exceptions in accordance with 42 CFR 433.139 include the following situations in which the Contractor 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 thirty (30) calendar days after the date of service.
- The claim is for services provided that were covered by a third party at the time services were rendered or reimbursed (i.e., the Contractor was not aware of the third-party coverage); the Contractor must pursue reimbursement from potentially liable third parties.

8.8 Health Information Technology and Interoperability

The Contractor shall maintain plans to adopt, implement and actively participate in Health Information Technology (HIT) and interoperability initiatives in order to improve the quality, efficiency and outcomes of health care delivery in Indiana. The Contractor shall also cooperate and participate in the development and implementation of future FSSA-driven HIT initiatives.

Contractors are required to implement and maintain systems that meet the CMS Interoperability and Patient Access requirements in 42 CFR 438.242, 42 CFR 457.1233; 42 CFR 457.760, 42 CFR 438.62, and 42 CFR 438.10 introduced in the Interoperability and Patient Access Final Rule. This includes but is not limited to patient access and provider directory APIs and payer to payer data exchanges.

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Following are examples of HIT initiatives that the Contractor should actively be involved in, or otherwise have a plan to participate in:

- *Electronic Health Record (EHR)*. An electronic health record is a digital version of a patient's paper chart that contains medical and treatment histories of patients. EHRs are real-time patient centered records that make information available instantly and securely to authorized users. They are built to share information with other health care providers and organizations in order to coordinate information for and from all clinicians involved in a patient's care such as: medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results. Appropriate technical, administrative, and physical safeguards should also be in place to protect patient health information contained in the EHR. To ensure interoperability among providers including laboratory, pharmacy, radiology, inpatient hospital/surgery center, outpatient clinical care, home health, public health and others, organizations at the national level (including the Health IT Standards Panel and the Certification Commission for Health IT) are working to develop standards related to IT architecture, messaging, coding, and privacy/security and a certification process for technologies. The Contractor is strongly encouraged to use these standards in developing their electronic data sharing initiatives.

- *Electronic Prescribing.* The ability to generate and transmit permissible prescriptions electronically. Effective August 24, 2017 Indiana began to implement a statewide, comprehensive platform for healthcare professionals to review patients' controlled-substance prescription history more quickly and efficiently. This platform supports Indiana's Prescription Drug Monitoring Program (INSPECT) and transfers data into electronic health records and pharmacy management systems. Statewide integration of the INSPECT platform is a key component of Indiana's ongoing efforts to attack the opioid crisis.

- *Health Information Exchanges (including Regional Health Information Organizations – RHIOs)*. These exchanges, such as the Indiana Health Information Exchange (IHIE), 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. The Contractor shall develop strategies to promote connectivity and integration with Health Information Exchanges. The Contractor shall contract with at least one Health Information Exchange in Indiana to receive clinical data, such as emergency room admissions.

- *Benchmarking*. Contractors can pool data from multiple providers and "benchmark" or compare metrics related to outcomes, utilization of services and populations. Practice pattern analysis, with appropriate risk adjustment, can help to identify differences in treatment of patients and best practices. Information can be shared with Contractors and providers to help them identify opportunities for improvement, or can be linked to pay for performance initiatives.

- *Telemedicine*. Telemedicine allows provider-to-provider and provider-to-member interactions through the use of telecommunications and information technology, and is especially useful in situations where members do not have easy access to a provider, such as in rural areas. Providers also use telemedicine to consult with each other and share their expertise for the benefit of treating complex patients. The Contractor shall develop reimbursement mechanisms to encourage appropriate use of telemedicine.

- *Mobile and Self-Service Technology*. The Contractor shall utilize mobile and self-service technology in delivering services to members. This includes, but is not limited to, remote

monitoring devices to enable members to record health measures for delivery to the Contractor and/or physician practices, as well as medication and appointment reminders through personalized voice or text messages.

- *Admission, Discharge, and Transfer (ADT) alerts*. ADT alerts are automatic electronic notifications of admissions, discharges, and transfers that are sent to a patient's primary care physician or other healthcare provider. Implementing ADT alerts help to reduce avoidable hospital readmissions and improves care transitions and coordination. The Contractor will promote provider utilization of ADT alerts and integrate their monitoring into health plan operations and delivery of care.

9.0 Performance Reporting and Incentives

FSSA places great emphasis on the delivery of quality health care to Hoosier Care Connect members. Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered in Hoosier Care Connect. The State will use various performance targets, industry standards, national benchmarks and program-specific standards in monitoring the Contractor's performance and outcomes. The State reserves the right to publish Contractor performance and/or recognize the Contractor when it exceeds performance indicators. Additionally, beginning in year two (2) of the Contract, the State intends to utilize performance outcomes as a factor for auto-assignments and enrollment materials developed to facilitate member choice of an MCE.

The Contractor must comply with all reporting requirements and must submit the requested data. The State reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors.

The Contractor must have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to FSSA is accurate. In accordance with 42 CFR 438.604 and 42 CFR 438.606 all data must be certified by the Contractor's Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to one of these employees. The certification must attest, based on best knowledge, information and belief to the accuracy, completeness and truthfulness of the data and documents submitted to the State. This certification must be submitted concurrently with the certified data. As an example only, the current Reporting Manual is provided in the Bidders' Library.

FSSA reserves the right to audit the Contractor's self-reported data and change reporting requirements at any time with reasonable notice. FSSA may require corrective action as outlined in Contract Exhibit 2 Contract Compliance and Pay for Outcomes for Contractor non-compliance with these and other subsequent reporting requirements and performance standards. FSSA may change the frequency of reports and may require additional reports at any time. In these situations, FSSA shall provide at least thirty (30) calendar days' notice to the Contractor before changing reporting requirements. FSSA may request ad hoc reports at any time.

The Reporting Manual will detail reporting requirements and the full list of required reports. The Contractor shall comply with all State instructions regarding submission requirements, including but not limited to, formatting, timeliness and data uploading instructions.

FSSA may schedule meetings or conference calls with the Contractor upon receiving the performance data. When FSSA identifies potential performance issues, the Contractor must formally respond in writing to these issues within five (5) business days of the receipt of the feedback meeting or conference call. If the Contractor fails to provide a formal, written response to the feedback or fails to respond within five (5) business days, FSSA may consider the vendor(s) noncompliant in its performance reporting and may implement corrective actions.

9.1 Administrative and Financial Reports

Financial Reports assist FSSA in monitoring the Contractor's financial trends to assess its stability and continued ability to offer health care services to its members. If the Contractor does not meet the financial reporting requirements, FSSA will notify the Contractor of the non- compliance and designate a period of time, not less than ten (10) calendar days, during which the Contractor must provide a written response to the notification. Contractors must meet IDOI licensure and financial requirements. Examples of Financial Reports to be submitted by the Contractor, in accordance with the terms of the Reporting Manual, include but are not limited to:

- IDOI Filing;
- Reimbursement for FQHC and RHC Services;
- Physician Incentive Plan Disclosure;
- Encounter Data Quality Validation template;
- Insurance Premium Notice;
- Capitation Reconciliation Report;
- Vendor Contact Sheet; and
- Key Staff and Other Staffing

On an annual basis, the Contractor must submit audited financial reports specific to this contracted Medicaid program. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. Audits should be performed for calendar years using data on a services incurred basis with six months of claims run-out.

9.2 Member Service Reports

Member Service Reports identify the methods the Contractor uses to communicate to members about preventive health care and program services and monitor member satisfaction.

FSSA reserves the right to require more frequent Member Service reporting at the beginning of the Contract and as necessary to ensure satisfactory levels of member service.

9.3 Network Development Reports

Network Development Reports assist FSSA in monitoring the Contractor's network composition by specialty and GeoAccess ratios in order to assess member access and network capacity. The Contractor must identify current enrollment, gaps in network services and the corrective actions that the Contractor is taking to resolve any potential problems relating to network access and capacity.

FSSA will require more frequent Network Geographic Assessment reporting at the beginning of the Contract, until the Contractor demonstrates that the network access standards have been met for all Contractors new to the program.

9.4 Provider Service Reports

Provider Service Reports assist FSSA in monitoring the methods the Contractor uses to communicate to providers about clinical, technical and quality management and improvement issues relating to the program.

9.5 Quality Management Reports

Quality Management Reports document the methods and processes the Contractor uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports assist FSSA in monitoring the Contractor's quality management and improvement activities.

9.6 Utilization and Authorization Reports

Utilization Reports assist FSSA in monitoring the Contractor's utilization trends, performance and progress towards performance targets. The Contractor will monitor utilization by subpopulation when appropriate and as directed by FSSA.

9.6.1 Prior Authorization Detail

The State reserves the right to require the Contractor to submit regular prior authorization detailed information on every prior authorization request received and processed in an electronic State specified format.

9.7 Care Coordination Reports

Care Coordination Reports assist FSSA in monitoring the Contractor's provision of disease management, care management, complex case management and RCP. The Contractor must submit data including but not limited to, the number of members enrolled and disenrolled, average contact counts per member, number of care plans developed and the average program participation length.

9.8 Claims Reports

Claims Reports assist FSSA in monitoring the Contractor's claims processing activities to ensure appropriate member access to services and payments to providers. The Contractor must submit claims processing and adjudication data. The Contractor must also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing.

9.9 Health Outcomes and Clinical Reporting

Health Outcomes and Clinical Reports assist FSSA in monitoring the health status of Hoosier Care Connect enrollees and to identify the effectiveness of Contractor interventions.

9.10 CMS Reporting

The Contractor shall be required to submit data requested by CMS. For example, in preparation for any conference calls with CMS, FSSA will ask the Contractor for data requested by CMS. The Contractor shall submit this data in the timeframe and format specified by FSSA.

9.11 Other Reporting

FSSA reserves the right to require additional reports to address program-related issues as determined by FSSA to be necessary for program monitoring.

10.0 Failure to Perform/Non-compliance Remedies

It is the State's primary goal to ensure that the Contractor is delivering quality care to members. To assess attainment of this goal, the State will routinely monitor certain quality and performance standards, and will hold the Contractor accountable for being in compliance with the Contract terms at all times. FSSA will work collaboratively with the Contractor to maintain and improve programs, and not to impair health plan stability.

In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Contract or the Reporting Manual, the State will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies set forth in Contract Exhibit 2 Contract Compliance and Pay for Outcomes. The State will provide written notice of non-compliance to the Contractor within sixty (60) calendar days of the State's discovery of such non-compliance.

Notwithstanding the foregoing, any failure or delay on the part of the State in providing written notice or otherwise exercising any right, power or remedy under the Contract will not operate as a waiver of such right, power or remedy, and no single or partial exercise of any such right, power, or remedy will preclude any other or further exercise of such right, power or remedy. Except as specifically set forth herein, the rights and remedies available pursuant to this Contract are cumulative in nature and not alternative. For example, if FSSA elects not to exercise a corrective action clause contained anywhere in the Contract in a particular instance, this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the Contract, may be retroactively assessed.

11.0 Termination Provisions

11.1 Contract Terminations

FSSA reserves the right to terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any term or condition of the Contract, or failure to take corrective action as required by FSSA to comply with the terms of the Contract.

The Contract between the State and the Contractor may be terminated as follows:

- By mutual written agreement of the State and Contractor;
- By the Contractor, subject to the remedies listed in the Contract;
- By the State, in whole or in part, whenever the State determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within thirty (30) calendar days after receipt of a notice specifying those conditions;
- By the State, in whole or in part, whenever, for any reason, the State determines that such termination is in the best interest of the State, with at least thirty (30) calendar days' prior notice to the Contractor. Such termination is referred to herein as "Termination for Convenience;"

- By the State, in whole or in part, whenever funding from state, federal or other sources are withdrawn, reduced or limited, with sufficient prior notice to the Contractor; or

- By the State, in whole or in part, whenever the State determines that the instability of the Contractor's financial condition threatens delivery of Medicaid services and continued performance of Contractor responsibilities.

The State will provide the Contractor with a hearing prior to contract termination in accordance with 42 CFR 438.708.

11.1.1 Termination by the State for Contractor Default

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor or a subcontractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable or unwilling to cure such failure within thirty (30) calendar days, or such other reasonable period of time as specified in writing by the State, taking into consideration the gravity and nature of the default. Such termination is referred to herein as "Termination for Default."

Upon determination by the State that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities, the Contractor must be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable or unwilling to cure the failure within the specified time period, the State will notify the Contractor that the Contract, in full or in part, has been terminated for default.

If, after providing notice of Termination for Default, it is determined by either the State or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Contractor or any of its subcontractors, the notice of termination will not be considered a Termination for Default, but must be deemed to have been issued as a Termination for Convenience, and the rights and obligations of the parties must be governed accordingly.

In the event of Termination for Default, in full or in part, as provided under this clause, the State may procure, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the State for costs incurred to procure such similar supplies or services as are needed to continue operations.

In the event of a Termination for Default prior to the start of operations, any claim the Contractor may assert must be governed by the procedures defined in the Contract. In the event of a Termination for Default during ongoing operations, the Contractor will be paid for any outstanding capitation payments due, less any assessed damages. The rights and remedies of the State provided in this Section 11.1.1 are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

11.1.2 Termination for Financial Instability

The State may terminate the Contract immediate upon the occurrence of any of the following events:

- The Contractor becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under the Contract;

- The Contractor ceases to conduct business in normal course;
- The Contractor makes a general assignment for the benefit of creditors; or
- The Contractor suffers or permits the appointment of a receiver for its business or assets.

The State may, at its option, immediately terminate the Contract effective at the close of business on the date specified. In the event the State elects to terminate the Contract under this provision, the Contractor must be notified in writing, by either certified or registered mail, specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor must immediately inform the Contract Administrator as specified in the Contract between the State and the Contractor. The Contractor must ensure that all tasks related to the subcontract are performed in accordance with the terms of the Contract.

11.1.3 Termination for Failure to Disclose Records

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor has failed to make available to any authorized representative of the State, any administrative, financial or medical records relating to the delivery of services for which State Medicaid program dollars have been expended.

In the event that the State terminates the Contract pursuant to this provision, the Contractor must be notified in writing, either by certified or registered mail, either sixty (60) calendar days prior to or such other reasonable period of time prior to the effective date, of the basis and extent of the termination. Termination must be effective as of the close of business on the date specified in the notice.

11.1.4 Termination by the Contractor

The Contractor must give advance written notice of termination, or intent not to renew, to the State a minimum of one hundred eighty (180) calendar days prior to termination or expiration. The effective date of the termination must be no earlier than the last day of the month in which the one hundred and eightieth (180th) day falls. Termination of the Contract by the Contractor is subject to damages listed in Section 11.4.

11.2 Termination Procedures

When termination is anticipated, FSSA will deliver to the Contractor a Notice of Termination by certified or registered mail specifying the nature of the termination and the date upon which such termination becomes effective. Within ten (10) calendar days of receipt of the Notice of Termination, the Contractor must submit a written plan of termination ("Transition Plan") for FSSA's approval.

The Transition Plan shall, at minimum, address the following:

- Stopping work under the Contract on the date and to the extent specified in the Notice of Termination.
- Placing no further orders or subcontracts for materials, services or facilities.
- Notifying all of the Contractor's members regarding the date of termination and the process by which members will continue to receive medical care. FSSA must approve all member notification materials in advance of distribution.

- Terminating all orders and subcontracts, to the extent that they relate to the performance of work terminated by the Notice of Termination.

- Assigning activities to the State, its designee or successor contractor, in the manner and to the extent that they relate to the performance of work terminated by the Notice of Termination.

- Assigning to the State, its designee or successor contractor, in the manner and to the extent directed, all of the rights, titles and interests of the Contractor under the orders or subcontracts so terminated.

- With the approval of the State, settling outstanding liabilities and all claims arising out of such termination of orders and subcontracts.

- Within ten (10) business days from the effective date of the termination, transferring title to the State of Indiana (to the extent that title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information and documentation, in any form that relates to the work terminated by the Notice of Termination.

- Completing the performance of such part of work that has not been specified for termination by the Notice of Termination.

- Taking such action as may be necessary, or as the State may direct, for the protection and preservation of the property related to the Contract that is in the possession of the Contractor and in which the State has or may acquire an interest.

- Providing for all the Contractor's responsibilities set forth in Section 11.3.

The requirements listed above are illustrative only and do not limit or restrict the State's ability to require the Contractor to address additional issues in its Transition Plan. The State shall withhold the Contractor's final capitation payment until the Contractor has (a) received FSSA approval of its Transition Plan, and (b) completed the activities set forth in its Transition Plan, as well as any additional activities requested by FSSA, to the satisfaction of FSSA, in its sole discretion.

11.3 Contractor Responsibilities upon Termination or Expiration of the Contract

Termination or expiration of the Contract does not discharge the obligations of the Contractor with respect to services or items furnished prior to termination or expiration of the Contract, including retention of records and verification of overpayments or underpayments. Termination or expiration of the Contract does not discharge the State's payment obligations to the Contractor or the Contractor's payment obligations to its subcontractors and providers. Upon termination or expiration of the Contract, the Contractor must:

- Assist the State in taking the necessary steps to ensure a smooth transition of services after expiration or termination of the Contract.

- Provide a written Transition Plan for the State's approval, in accordance with Section 11.2. In the event of Contract termination, the Transition Plan shall be due within ten (10) calendar days of receiving Notice of Termination from the State. In the event of Contract expiration, the Transition Plan shall be due at least one hundred eighty (180) calendar days prior to expiration of the Contract. The Contractor will revise and resubmit the

Transition Plan to the State on a regular basis, the frequency of which will be determined by the State.

- Appoint a liaison for post-transition concerns.
- Provide for sufficient claims payment staff, member services staff, and provider services staff to ensure a smooth transition.
- Provide the State with all information requested by the State in the format and within the timeframes set forth by the State, which shall be no later than thirty (30) calendar days of the request.
- Assist the State and/or its subcontractors in FQHC/RHC settlement process for settlement periods prior to the day of termination or expiration of the Contract. Requested assistance may include but is not limited to data support for questions regarding FQHC/RHC claims data and reports and the submission of claims data files to the State and/or its vendors.
- Be financially responsible for all claims with dates of service through the day of termination or expiration of the Contract, including those submitted within established time limits after the day of termination or expiration of the Contract.
- Be responsible for submitting encounter data to the State for all claims incurred prior to the contract expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after termination or expiration of the Contract.
- Be responsible for submitting all reports necessary to facilitate the collection of pharmacy rebates and assisting in the resolution of all drug rebate disputes with the manufacturer for all claims incurred prior to the contract expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after the termination or expiration of the Contract.
- Be responsible for submitting all performance data with a due date following the termination or expiration of the Contract, but covering a reporting period prior to termination or expiration of the Contract, including but not limited to CAHPS, HEDIS, Reimbursement for FQHC and RHC Services and the Capitation Rate Calculation Sheet.
- Be responsible for resolving member grievances and appeals with respect to claims with dates of service prior to the day of contract termination or expiration, including grievances and appeals filed on or after the day of Contract termination or expiration but with dates of service prior to the day of Contract termination or expiration.
- Be financially responsible for inpatient services for patients hospitalized on or before the day of Contract termination or expiration through the date of discharge, including the DRG payment and any outlier payments.
- Be financially responsible for services rendered through the day of termination or expiration of the Contract, for which payment is denied by the Contractor and subsequently approved upon appeal by the provider.
- Be financially responsible for member appeals of adverse decisions rendered by the Contractor concerning treatment of services requested prior to termination or expiration of the Contract which are subsequently upheld on behalf of the member after an appeal proceeding or after a FSSA Fair Hearing.

- Arrange for the orderly transfer of patient care and patient records to those providers who will assume care for the member. For those members in a course of treatment for which a change of providers could be harmful, the Contractor must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged. The Contractor shall transfer all applicable clinical information on file, including but not limited to approved and outstanding prior authorization requests and a list of members in case or care management, to the State and/or the successor MCE at least fourteen (14) business days prior to the day of termination or expiration of the Contract. A final file shall be provided within five (5) business days of the termination or expiration of the Contract.

- Notify all members about the Contract termination and the process by which members will continue to receive medical care, at least sixty (60) calendar days in advance of the effective day of termination or expiration of the Contract. The Contractor will be responsible for all expenses associated with member notification. FSSA must approve all member notification materials in advance of distribution.

- Notify all providers about the Contract termination and the process by which members will continue to receive medical care, at least sixty (60) calendar days in advance of the effective day of termination or expiration of the Contract. The Contractor will be responsible for all expenses associated with provider notification. FSSA must approve all provider notification materials in advance of distribution.

- Report any capitation or other overpayments made by the State to the Contractor within thirty (30) calendar days of discovery and cooperate with investigations by the State or its subcontractors into possible overpayments made during the contract term. The Contractor shall return any capitation or other overpayments, including those discovered after contract expiration, to the State within fourteen (14) calendar days of reporting the overpayment to the State.

- Coordinate the continuation of care for members who are undergoing treatment for an acute condition.

- Be responsible to submit the HEDIS Auditor Report listed in Section 9.5, in accordance with the applicable due date, and to participate in the External Quality Review, as required by 42 CFR 438, Subpart E, for the final year of the Contract.

- The State, CMS, the OIG, the Comptroller General, and their designees have the right to audit records or documents of the Contractor and their subcontractors for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

- Comply with any additional items the State required the Contractor to address in its Transition Plan.

The State reserves the right to withhold some or all retroactive capitation adjustment payments due and owing to the Contractor in the event the Contractor fails to comply with the responsibilities set forth in this section, including its responsibilities related to data submission and support.

11.4 Damages

The Contractor acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State, which may not be adequately compensable in damages. The Contractor acknowledges that the State has incurred substantial expenses in connection with the preparation and entry into the Contract, including

expenses relating to training staff, data collection and processing, actuarial determination of capitation rates, and ongoing changes to the State's and its fiscal agent's management IT systems.

The Contractor further acknowledges and agrees that in the event the Contract is terminated prior to the end of the initial term or any renewal term, due to the actions of the Contractor or due to the Contractor's failure to fully comply with the terms and conditions of the Contract, the State will incur substantial additional expense in processing the disenrollment of all members and the related MMIS changes, in effecting staffing changes, in procuring alternative health care arrangements for members, and in other areas unknown to the State at this time. The Contractor accordingly agrees that the State may, in such event, seek and obtain actual damages.

The remedies available to the State under this Agreement include but are not limited to:

- Obtaining payment under the performance bond or other arrangement set forth in Section 2.4.4;

- Assessing actual damages measured by the cost to the State to transition members to other providers and/or another Contractor. This includes, but is not limited to, payments the State may make to other contractors to perform work related to the transition; and

- Assessing consequential damages measured by the loss of anticipated savings to the State the enrollment in Hoosier Care Connect was expected to realize.

Payment of the performance bond or other arrangement established under Section 2.4.4 is due within ten (10) calendar days of the date of termination. Payment of liquidated damages is due within thirty (30) calendar days from the date of termination. Payment of actual damages is due within ten (10) calendar days of the Contractor's receipt of the State's demand for payment.

11.5 Assignment of Terminating Contractor's Membership and Responsibilities

If the Contract is terminated for any reason, the State may assign the Contractor's membership and responsibilities to one (1) or more other MCEs who also provide services to the Hoosier Care Connect population, subject to consent by the MCE that would gain the member enrollment.

In the event that FSSA assigns members or responsibility to another MCE, during the final quarter of the Contract, the Contractor will work cooperatively with, and supply program information to, any successor MCEs. Both the program information and the working relationship among the Contractor and successor MCEs will be defined by the State.

11.6 Refunds of Advanced Payments

The Contractor must, within thirty (30) calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the Contract.

11.7 Termination Claims

If the Contract is terminated under this Section 11, the Contractor must be entitled to be paid a prorated capitation amount, determined by the State based on available information, for the month in which Notice of Termination was received for the service days prior to the effective date of termination. The Contractor will have the right of appeal, as stated under the subsection on Disputes in the Contract, of any such determination. The Contractor will not be entitled to payment of any services performed after the effective date of termination.

12.0 Member Copayments

Except for members exempt from cost sharing pursuant to Section 12.3, all Hoosier Care Connect members are responsible for making financial contributions to their health care coverage through copayments for certain services.

12.1 Member Copayments Obligations

As detailed in Section 4.13, the Contractor shall ensure that member copayments and premiums as set forth in this Section 12.0 do not exceed 5% of family income as calculated on a quarterly basis. The Contractor will work with the State to consider all contributions made by the household in the calculation and monitoring of the 5% contribution limit.

12.2 Hoosier Care Connect Member Copayments

Members enrolled in Hoosier Care Connect are required to pay the following copayments at the time services are rendered:

- $1-dollar ($1.00) copayment for one-way transportation services.
- $3-dollar ($3.00) copayment for pharmacy services.
- $3-dollar ($3.00) copayment for non-Emergency services provided in an Emergency room setting.

No copayment is required for preventative care, maternity services or family planning services.

The Contractor shall include copayment information on the member's ID card. The Contractor shall also establish education, policies and procedures for its contracted providers to collect copayments for Hoosier Care Connect members at the time of service.

12.3 Exempt Populations

Pursuant to federal law, the Contractor may not impose copayments on members who are pregnant, younger than 18 years old, and/or members identified as an American Indian/ Alaska Native (AI/AN) pursuant to 42 CFR 136.12. The State will identify all AI/AN members through the eligibility determination process.

EXHIBIT 2 CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Except as defined below or where the context requires otherwise, all capitalized terms shall have the meanings ascribed to them in the Contract.

Note that previous versions of this Exhibit that relate specifically to previous years (calendar year 2021) exist. The specific final requirements for each of these specified years, will regulate the requirements and calculations applied to each of these previous periods, unless changes specifically addressing previous years are made.

A. Contract Compliance

1. Non-compliance Remedies

It is the State's primary goal to ensure that the Contractor and its subcontractors/vendors deliver quality care to members while maintaining the program integrity of the State of Indiana's Hoosier Care Connect program. To assess attainment of this goal, the State monitors certain quality and performance standards, and holds the Contractor accountable for being in compliance with Contract terms. FSSA accomplishes this by working collaboratively with the Contractor to maintain and improve programs, and not to impair Contractor stability.

In the event that the Contractor and/or its subcontractors/vendors fails to meet performance requirements or reporting standards set forth in the Contract or other standards established by the State, the State will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies discussed below or in this contract. The State will provide written notice of non-compliance to the Contractor within sixty (60) calendar days of the State's discovery of such non-compliance.

If FSSA elects not to exercise a corrective action clause contained anywhere in the Contract in a particular instance, this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the Contract, may be retroactively assessed.

2. Corrective Actions

In accordance with 42 CFR 438, Subpart I, FSSA may require corrective action(s) when the Contractor has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The written notice of non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, any of the following:

- Written Warning: FSSA may issue a written warning and solicit a response regarding the Contractor's corrective action.

- Formal Corrective Action Plan: FSSA may require the Contractor to develop a formal corrective action plan to remedy the breach. The corrective action plan must be submitted under the signature of the Contractor's chief executive and must be approved by FSSA. If the corrective action plan is not acceptable, FSSA may provide suggestions and direction to bring the Contractor into compliance.

- Withholding Full or Partial Capitation Payments: FSSA may suspend capitation payments

for the following month or subsequent months when the State determines that the Contractor is materially non-compliant. FSSA must give the Contractor written notice ten (10) business days prior to the suspension of capitation payments and specific reasons for non-compliance that result in suspension of payments. The State may continue to suspend all capitation payments until non-compliance issues are corrected.

- Suspending Auto-assignment: FSSA may suspend auto-assignment of members to the Contractor. The State may suspend all auto-assignment or may selectively suspend auto-assignment for a region or county. The State will notify the Contractor in writing of its intent to suspend auto-assignment at least ten (10) business days prior to the first day of the suspension period. The suspension period may be for any length of time specified by the State. The State will base the duration of the suspension upon the nature and severity of the default and the Contractor's ability to cure the default.

- Assigning the Contractor's Membership and Responsibilities to Another Contractor: The State may assign the Contractor's membership and responsibilities to one (1) or more other Contractors that also provide services to the Hoosier Care Connect population, subject to consent by the Contractor that would gain that responsibility. The State must notify the Contractor in writing of its intent to transfer members and responsibility for those members to another Contractor at least ten (10) business days prior to transferring any members.

- Appointing Temporary Management of the Contractor's Plan: The State may assume management of the Contractor's plan or may assign temporary management of the Contractor's plan to the State's agent, if at any time the State determines that the Contractor can no longer effectively manage its plan and provide services to members.

- Contract Termination: The State reserves the right to terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any term or condition of this Contract, or failure to take corrective action as required by FSSA to comply with the terms of this Contract. The State must provide thirty (30) calendar days written notice and must set forth the grounds for termination.

3. Liquidated Damages

In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Contract, or other standards set forth by the State, it is agreed that damages shall be sustained by the State, and the Contractor shall pay to the State liquidated damages pursuant to this contract, its actual damages, and/or penalties as expressly permitted under 42 USC Chapter Seven, Subchapter XIX, Section 1396u-2 (e).

It is agreed that in the event of a failure to meet specified performance or reporting requirements subject to liquidated damages, it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the State will sustain in the event of, and by reason of, such failure; it is therefore agreed that the Contractor will pay the State for such failure according to the following subsections. No punitive intention is inherent in the following liquidated damages provisions.

FSSA may impose remedies resulting from failure of the Contractor to provide the requested services depending on the nature, severity and duration of the deficiency. In most cases, liquidated damages will be assessed based on this Exhibit. Should FSSA choose not to assess damages for an initial infraction or deficiency, it reserves the right to require corrective action or assess damages at any point in the future.

The State shall notify Contractor of liquidated damages due and Contractor shall pay the State the full amount of liquidated damages due within ten (10) business days of receipt of the State's

notice. The State may, in its sole discretion, elect at any time to offset any amount of liquidated damages due against capitation payments otherwise due Contractor pursuant to the Contract. In the event liquidated damages are imposed under the Contract, the Contractor must provide FSSA with a formal corrective action plan, as well as monthly reports on the relevant performance metrics until such time as the deficiency is corrected for a period of sixty (60) consecutive days.

If Contractor fails to submit any Priority Report in a timely, complete, and accurate manner (other than the HEDIS and CAHPS reports), Contractor shall pay liquidated damages of four thousand, eight hundred and eighty dollars ($4,880) for each Priority Report (other than the HEDIS or CAHPS reports) that is not submitted in a timely, complete, and accurate manner.

If Contractor fails to submit a HEDIS or CAHPS report that was based on the National Committee for Quality Assurance (NCQA) methodology for sampling data, Contractor shall pay liquidated damages of five thousand two hundred dollars ($5,200) for each business day the report is not submitted in a timely, complete, and accurate manner.

4. Non-compliance with Reporting Requirements

The Reporting Manual details the required formats, templates and submission instructions for the reports listed in the Contract. FSSA may change the frequency of required reports, or may require additional reports, at FSSA's discretion. The Contractor will be given at least thirty (30) calendar days' notice of any change to reporting requirements.
If the Contractor's non-compliance with the reporting requirements impacts the State's ability to monitor the Contractor's solvency, and the Contractor's financial position requires the State to transfer members to another Contractor, the State will require the Contractor to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement Contractor as a result of member transfer. In addition, the Contractor must pay any costs the State incurs to accomplish the transfer of members. Further, FSSA will withhold all capitation payments or require corrective action until the Contractor provides satisfactory financial data.

5. Priority Performance and Reporting Requirements

FSSA has assigned high priority to the following reports (collectively referred to herein as "Priority Reports"):

No	Title
A.	**Systems and Claims Reports**
0101	Claims Adjudication Summary
0102	Encounters Summary
0103	Claims Denial Reasons
0104	Paid Abortion Claims Summary
B.	**Member Services Reports**
0201	Member Helpline Performance
0202	Member Grievances and Appeals

0204	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Summary
C.	**Provider Services Reports**
0301	Provider Helpline Performance
0303	Provider Claims Disputes
D.	**Network Development and Access Reports**
0902	Count of Enrolled Providers
0903	Member Access to Providers
0905	24-Hour Availability Audit
0904	Subcontractor Compliance Summary Report
E.	**Quality Management and Improvement Reports**
1002	Quality Management and Improvement Program Work Plan
1001	Quality Improvement Projects
1004	HEDIS® Data Report
1005	HEDIS® Compliance Auditor's Final Report
1104	Annual Program Integrity Plan Report
F.	**Utilization Management Reports**
0514, 0515	Care/Complex Case Management Reports
0512	Health Needs Screen
0513	Comprehensive Health Assessment Tool Report
0509	Weeks of Pregnancy
G.	**Financial Reports**
0806	Indiana Department of Insurance (IDOI) Filing
1202, 1203	Annual Reimbursement for FQHC and RHC Services

0803	Encounter Data Quality (previously (CRCS)) Report
0802	Vendor Contact Sheet
0801	Key Staff Vacancy Report
H.	**Pharmacy Reports**
0505	Pharmacy Services Utilization Report
0506	Pharmacy Audit Report
I.	**Other Reports**
1.	Monthly Onsite Monitoring Tool
2.	CMS Required Reports

Minimum recommended sample sizes for Hybrid and Survey measures must be met. Any report which requires a minimum sample size (e.g., CAHPS, HEDIS) will be rejected if they do not meet the established minimum standards for sampling. If Contractor fails to submit any Priority Report by the required deadline or fails to utilize the required sample sizes, the Contractor may forfeit eligibility for participation in the pay for outcomes program as described in Section B.1 of this Exhibit and the Contractor will be subject to corrective actions as set forth in Section A.2 of this Exhibit.

6. Non-compliance with Other Reporting Requirements

If Contractor fails to submit in a timely, complete, and accurate manner any report which Contractor is required to provide under the Contract or the Reporting Manual, Contractor will pay liquidated damages of five hundred dollars ($500) per report for each business day for which such report has not been submitted correctly, complete, on time, and in the correct reporting format. The reports which Contractor is required to provide are identified in the Reporting Manual. Payment of liquidated damages does not relieve Contractor of its responsibility to provide any report required under the Contract.

7. Encounter Data Quality (previously CRCS) Report

FSSA recognizes the importance of monitoring Contractor performance throughout the calendar year, and Contractor will be required to submit quarterly Encounter Data Quality reports for validation to FSSA in a timely, complete and accurate manner, for the Hoosier Care Connect program in accordance with the reporting manual. Each quarterly report must include year-to-date information and must be verified to a degree of at least ninety-eight percent (98%) completeness for all claims (i.e., an incompleteness rate of no more than 2.0%).

The Reporting Manual details the requirements for submission of Encounter Data Quality reports.

FSSA will use Contractor's encounter data, or other method of data completion verification deemed reasonable by FSSA, to verify the completeness of the Encounter Data Quality reports

in comparison to Contractor's encounter claims. FSSA reserves the right to change the method of data completion verification upon reasonable advance notice to the Contractor.

Encounter Data Quality reports are considered Priority Reports. To the extent Encounter Data Quality data or underlying encounter data is used in a public report, it must be received by stated deadline in order to be published.

If, during any quarter after the first year of the Contract, Contractor fails to submit Encounter Data Quality reports to FSSA in a timely, complete and accurate manner, and does not meet the ninety-eight percent (98%) completeness threshold, the Contractor shall pay liquidated damages of forty-nine thousand, two hundred ($49,200), per quarter.

Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate Encounter Data Quality reports required under the Contract.

8. Non-compliance with Encounter Claims Submission Requirements

a. Weekly Batch Submission

The Contractor must submit at least one (1) batch of encounter data for paid and denied institutional, professional, and pharmacy claims in a standardized secure format, as specified by FSSA on a weekly basis. If, during any calendar month, Contractor fails to submit all encounter claims on a weekly basis when due, unless delay is caused by technical difficulties of FSSA or its designee, Contractor will pay liquidated damages in the amount of four thousand, eight hundred fifty dollars ($4,850) for each claim type for which shadow/encounter claims were not submitted in a timely manner.

b. Pre-cycle Edits

For each weekly encounter claims batch submission, Contractor must achieve no less than a ninety-seven percent (97%) compliance rate with pre-cycle edits. The State will assess pre-cycle edit compliance based upon the average compliance rate of the weekly encounter claims batch submissions made during the calendar month and will calculate compliance separately for institutional, professional and pharmacy claims. If the average compliance rate is below ninety-seven percent (97%) for any type of encounter claim, Contractor will pay liquidated damages in the amount of five thousand, four hundred sixty dollars ($5,460.00) for each deficient encounter claim type. For purposes of this section there are three (3) encounter claims types: institutional, professional and pharmacy. Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate encounter claims required under the Contract.

9. Prescription Drug Rebate File

Contractor shall comply with the required layouts for submitting pharmacy claim extracts used to support federal drug rebate invoicing and collection. The frequency of file submissions and the content of the files supporting drug rebate invoicing and collection are defined by FSSA and pertain to all pharmacy claim transactions and medical claim transactions that contain physician administered drugs as set forth in Section 3.8 of the Scope of Work. Contractor shall provide this reporting to FSSA in the manner and timeframe prescribed by FSSA, including, but not limited to, through a rebate file to the State or its designee. For any instance in which the Contractor fails to provide required files for drug rebate purposes in a timely, accurate or complete manner, the Contractor shall be responsible for interest, based on the interest calculation for late rebate payments methodology published by CMS, on delayed rebate money owed to the State. For example, if the Contractor fails to meet the FSSA established deadline for submission of the claim extracts and/or rebate file and the drug rebate contractor completes the quarterly drug rebate invoicing process without the Contractor's claim information for the

invoicing quarter, the Contractor shall reimburse the State for interest on the rebate amount later calculated by the drug rebate contractor, for the period of delay in collecting the rebate amount. Such reimbursement shall be due within thirty (30) days of presentation of the interest calculation.

10. Network Access

If FSSA determines that the Contractor has not met the network access standards established in the Contract, FSSA shall require submission of a Corrective Action Plan to FSSA within ten (10) business days following notification by the State. Determination of failure to meet network access standards shall be made following a review of the Contractor's Network Geographic Access Assessment Report. The frequency of required report submission will be outlined in the Reporting Manual. Contractor will pay liquidated damages in the amount of five thousand, two hundred, and fifty dollars ($5,250) for each reporting period that the Contractor fails to meet the network access standards. Upon discovery of noncompliance, the Contractor shall be required to submit monthly Network Geographic Access Assessment Reports until compliance is demonstrated for sixty (60) consecutive days. FSSA may also require the Contractor to maintain an open network for the provider type for which the Contractor's network is non-compliant. Further, should Contractor be out of compliance for three (3) consecutive months as a result of failure to meet network access standards, FSSA shall immediately suspend auto-enrollment of members with the Contractor, until such time as Contractor successfully demonstrates compliance with the network access standards.

11. Marketing Violations

If FSSA determines that Contractor has violated the requirements of Contractor's obligations with respect to marketing and marketing materials as set forth in Section 4.1 of the Scope of Work and 42 CFR 438.104, Contractor will pay liquidated damages of five thousand, nine hundred and eighty five dollars ($5,985.00) for each instance that such determination of a violation is made. For illustration purposes only, a violation will be determined to exist if Contractor distributed, directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by FSSA or that contain inaccurate, false or misleading information.

12. Member and Provider Communication and Education Violations

If FSSA determines that Contractor has violated the requirements of Contractor's obligations with respect to member and/or provider communication or education materials as set forth in Section 4.9 and Section 6.8.1 of the Scope of Work and 42 CFR 438.104, Contractor will pay liquidated damages of one thousand, one hundred and fifty five dollars ($1,155.00) for each instance that such determination of a violation is made. In addition, FSSA reserves the right to require an immediate retraction or correction by the Contractor, in a format acceptable to FSSA. For illustration purposes only, a violation will be determined to exist if Contractor promulgated or distributed, directly or indirectly through any agent or independent contractor, member and/or provider communication or education materials that have not been approved by FSSA or that contain inaccurate, false or misleading information. For further illustration, a violation will be determined to exist if the Contractor distributes any member or provider communication, including member or provider letters, bulletins, alerts, press releases or other press communications, bulletins and forms, without prior approval by FSSA. For purposes of this Exhibit, provider communications are limited to provider communications related to the Hoosier Care Connect program.

13. Claims Payment

If Contractor fails to pay or deny ninety-eight percent (98%) or more of any type of clean claims within the required timeframe, Contractor shall pay liquidated damages in the amount

of five thousand, seven hundred dollars ($5,700.00) for each deficient claims type. For the purposes of this Section there are six (6) claims types: professional paper claims, professional electronic claims, facility paper claims, facility electronic claims, pharmacy paper claims, and pharmacy electronic claims.

14. Provider Claim Disputes

Contractor must resolve and respond to ninety-nine percent (99%) of provider informal claim disputes within thirty (30) calendar days of receipt of the dispute. The Contractor must resolve and respond to ninety-nine percent (99%) of provider formal disputes within forty-five (45) calendar days of the receipt of the dispute. For each quarter in which Contractor fails to provide and communicate a timely resolution on ninety-nine percent (99%) of informal and/or formal disputes, Contractor shall pay liquidated damages in the amount of two thousand, three hundred and ten dollars ($ 2,310.00).

15. Readiness Review

If Contractor fails to satisfactorily pass the readiness review at least thirty (30) calendar days prior to scheduled member enrollment (or other deadline as may be established at the sole discretion of the State), the State may delay member enrollment and/or may require other remedies (including, but not limited to contract termination), and Contractor shall be responsible for all costs incurred by the State as a result of such delay.

In addition, for each business day that Contractor fails to submit readiness review processes beyond their expected due date, Contractor shall pay liquidated damages in the amount of five thousand, four hundred and fifty dollars ($5,450). Damages will be assessed each time the requirements are not met. In each instance that Contractor fails to submit substantially complete and accurate readiness review responses, Contractor shall pay liquidated damages in the amount of three thousand fifty dollars ($3,050).

16. Member/Provider Helpline and Website Services

There are twelve (12) separate measures that will equally apply to the Hoosier Care Connect Member/Provider Helpline and Website Metrics and the Pharmacy Helpline and Website Metrics Reports. For each instance in which FSSA finds the Contractor has failed to meet a metric for a given quarter, the Contractor shall pay liquidated damages in the amount of one thousand, four hundred seventy dollars ($1,470.00) per quarter of noncompliance for each metric.

Helpline and Website Metrics: The twelve (12) metrics are as follows:

i. For any calendar month, at least ninety-seven percent (97%) of all phone calls to the Helpline must reach the call center menu within thirty (30) seconds or the prevailing benchmark established by NCQA.

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

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

iv. If Contractor does not maintain an approved automated call distribution system, for any

calendar month, at least ninety-five percent (95%) of all phone calls to the Helpline must be answered within thirty (30) seconds.

v. For any calendar month, the busy rate associated with the Helpline shall not exceed zero percent (0%).

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

vii. For any calendar month, the lost call (abandonment) rate associated with the Helpline shall not exceed five percent (5%).

viii. Contractor must maintain an answering machine, voice mail system or answering service to receive calls to the Helpline that take place after regular business hours. For any calendar month, one hundred percent (100%) of all after hours calls received must be returned or attempted to be returned within one (1) business day.

ix. Contractor must maintain a system to receive and address electronic inquiries via e-mail and through the member website. For any calendar month, one hundred percent (100%) of all electronic inquiries received must be responded to within one (1) business day.

x. Contractor's Helpline for one hundred percent (100%) of operating hours must be properly equipped to accept calls including, without limitation, calls from members with limited English proficiency and calls from members who are deaf, hearing impaired or have other special needs.

xi. For any calendar month, eighty-five percent (85%) of all calls to the Helpline must be resolved during the initial call.

xii. Contractor must make pertinent information available to members and providers through an Internet website in an FSSA-approved format in accordance with the terms of the Contract. The website must be available for access by members no less than twenty three and one-half (23.5) hours per day, on average.

17. Prior Authorization

Contractor must respond to requests for authorization of services in the format and within the timeframes set forth in the Contract. For each quarter in which the Contractor fails to adjudicate ninety-eight percent (98%) or more of prior authorization requests within the required timeframes, Contractor shall pay liquidated damages in the amount of six thousand, six hundred and fifteen dollars ($6,615.00).

18. Continuity of Care

The Contractor shall honor outstanding authorizations for a minimum of ninety (90) calendar days when a member transitions to the Contractor from another source of coverage. The Contractor must pay any costs the State incurs associated with failure by the Contractor to honor outstanding authorizations as specified herein.

19. Member Grievances

Contractor must resolve one hundred percent (100%) of member grievances within thirty (30) calendar days of receipt of the grievance. For each quarter in which Contractor fails to provide and communicate a timely resolution on one hundred percent (100%) of member grievances,

Contractor shall pay liquidated damages in the amount of three thousand one hundred and fifty dollars ($3,150.00).

20. Member Appeals

Contractor must resolve one hundred percent (100%) of member appeals within thirty (30) calendar days of receipt of the appeal. For each quarter in which Contractor fails to provide and communicate a timely resolution on one hundred percent (100%) of member appeals, Contractor shall pay liquidated damages in the amount of two thousand, three hundred and ten dollars ($2,310.00).

The Contractor must also provide a timely and satisfactory response to documentation required to facilitate member appeals in accordance with the FSSA Fair Hearing process. In addition, the Contractor shall provide a representative to participate in the FSSA Fair Hearing process to represent the State. For each instance in which the Contractor fails to either (i) provide a timely response to documentation required for the member appeal within the time frames set forth by FSSA, or (ii) upon adequate notice, represent the State at the FSSA Fair Hearing, Contractor shall pay liquidated damages in the amount of one thousand one hundred dollars ($1,100).

21. Provider Credentialing

Contractor shall process all credentialing applications within thirty (30) calendar days of receipt of a complete application. If FSSA determines that the Contractor has not processed all credentialing applications in a timely manner, FSSA shall require submission of a formal Corrective Action Plan within ten (10) business days following notification by the State. Upon discovery of noncompliance, Contractor shall be required to submit monthly provider credentialing reports until compliance is demonstrated for sixty (60) consecutive days.

22. Complaints and Internet Quorum Inquiries

The Contractor must resolve complaints and Internet Quorum (IQ) inquiries to FSSA's satisfaction, within the timeframes set forth by FSSA. Unless an alternative deadline is identified by FSSA for a specific IQ inquiry, IQ inquiries must be resolved in no more than five (5) business days. The Contractor may request additional time to respond, but FSSA is under no obligation to grant extensions. For each instance in which the Contractor fails to provide a timely and accurate response to complaints or IQ inquiries within the timeframes set forth by FSSA, Contractor shall pay liquidated damages in the amount of four hundred dollars ($400.00).

23. Notification of System Outages

Contractor shall notify FSSA, at minimum, within two (2) hours of discovery of a disaster or other disruptions in its normal business operations. Contractor will be subject to corrective actions as set forth in Section A.2 of this Exhibit for failure to provide notification within two (2) hours of discovery.

24. Restoring Operations Following a Disaster

Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within twenty-four (24) hours of identification of a disaster. If the Contractor's failure to restore operations requires the State to transfer members to another Contractor, to assign operational responsibilities to another Contractor or the State is required to assume the operational responsibilities, the State will require the Contractor to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement Contractor. In addition, the Contractor must pay any costs the State incurs

associated with the Contractor's failure to restore operations following a disaster, including but not limited to costs to accomplish the transfer of members or reassignment of operational duties.

25. Advanced Notice of System Upgrades and Replacements

Contractor shall notify FSSA at least thirty (30) calendar days prior to the installation or implementation of minor software and hardware changes, upgrades, modifications or replacements and at least ninety (90) calendar days prior to the installation or implementation of major software or hardware changes, upgrades, modifications or replacements as defined in Section 8.0 of the Scope of Work. Contractor will be subject to corrective actions as set forth in Section A.2 of this Exhibit for failure to provide advanced notice in the required timeframe and may be required to delay implementation of the planned upgrade, modification or replacement.

26. Health Insurance Portability and Accountability Act (HIPAA) and Security Breaches

Contractor shall notify FSSA within one (1) business day upon discovery of a HIPAA, 42 CFR Part 2, or other security breach. Contractor shall be subject to corrective actions as set forth in Section A.2 of this Exhibit for failure to provide advanced notice in the required timeframe and must pay any costs the State incurs as a result of the violation.

27. Plan Solvency

If Contractor fails to meet solvency performance standards set forth below and as may be amended by the State, Contractor will be subject to corrective actions as set forth in the Contract, including but not limited to contract termination.

a. On a quarterly basis, current ratio (assets to liability) will be greater than or equal to one (1).

b. On a quarterly basis, the number of days cash on hand will not be fewer than sixty (60) business days. FSSA reserves the right to adjust the required number of days of cash on hand based on historical Contractor performance and the ability of the Contractor to demonstrate solvency.

c. On a quarterly basis, days in unpaid claims will not be greater than sixty-five (65) business days.

d. On a quarterly basis, days in claims receivables will not be greater than thirty (30) business days.

e. On a quarterly basis, equity (net worth) will be maintained at or above one hundred and fifty dollars ($150) per member.

28. Non-compliance with General Contract Provisions

The objective of this requirement is to provide the State with an administrative procedure to address issues where the Contractor is not compliant with the Contract. Through routine monitoring, the State may identify Contract non-compliance issues. If this occurs, the State will notify the Contractor in writing of the nature of the non-performance issue. The State will establish a reasonable period of time, but not more than ten (10) business days, during which the Contractor must provide a written response to the notification. If the Contractor does not correct the non-performance issue within the specified time, the State may enforce any of the remedies listed in this Exhibit.

Specifically, the State may enforce any of the remedies listed if the Contractor does the following:

- Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Contract with the State, to a member;
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Hoosier Care Connect program;
- Acts to discriminate among members on the basis of their health status or need for health care services, such as unlawful termination or refusal to re-enroll a member or engaging in any practice that would reasonably be expected to discourage enrollment by a potential enrollee whose medical condition or history indicates probable need for substantial future medical services;
- Misrepresents or falsifies information that it furnishes to CMS or to the State;
- Misrepresents or falsifies information that it furnishes to a member, potential enrollee, or health care provider;
- Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210;
- Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

29. FSSA Required Trainings

The Contractor shall ensure that any MCE staff member given a FSSA email completes all FSSA required trainings. Unless an alternative deadline is identified by FSSA for a specific training, all FSSA required trainings must be completed by its respective due date. The Contractor may request additional time to complete but FSSA is under no obligation to grant extensions.

30. Other Non-Performance

If Contractor fails to meet the other performance standards set forth in the Contract, Contractor will be subject to corrective actions as set forth in the Contract.

B. Pay for Outcomes Program

1. Program Establishment and Eligibility

FSSA has established a pay for outcomes program under which Contractor may receive additional compensation if certain conditions are met. The state encourages plans to share earned incentive payments with members and providers. The compensation under the pay for outcomes program is subject to Contractor's complete and timely satisfaction of its obligations under the Contract. This includes but is not limited to timely submission of the Contractor's HEDIS Report for the measurement year and the Certified HEDIS Compliance Auditor's attestation, as well as timely submission of the Priority Reports listed in Section A.5 of this Exhibit. In furtherance of the foregoing and not by limitation, the Contractor may, in FSSA's discretion, lose eligibility for its compensation under the pay for outcomes program if:

i. FSSA has suspended, in whole or in part, capitation payments or enrollment to the Contractor;

ii. FSSA has assigned, in whole or in part, the membership and responsibilities of Contractor to another participating managed care plan contractor;

iii. FSSA has assumed or appointed temporary management with respect to the Contractor;

iv. The Contract has been terminated;

v. The Contractor has, in the determination of the Director of the Office of Medicaid Policy and Planning, failed to execute a smooth transition at the end of the Contract term, including failure to comply with the Contractor responsibilities set forth in the Scope of Work; or

vi. Pursuant to the Contract including without limitation this Exhibit, FSSA has required a corrective action plan or assessed liquidated damages against Contractor in relation to its performance under the Contract during the measurement year.

FSSA may, at its option, reinstate Contractor's eligibility for participation in the pay for outcomes program once Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract, and FSSA has satisfactory assurances of acceptable future performance.

2. Incentive Payment Potential

During each measurement year, FSSA will withhold a portion of the approved capitation payments from Contractor as follows:

- Calendar Year 2021 – one point eight five percent (1.85%)
- Calendar Year 2022 – one point eight five percent (1.85%)
- Calendar Year 2023 – two percent (2%)
- Calendar Year 2024 – two point one five percent (2.15%)
- Calendar Year 2025 – two point one five percent (2.15%)
- Calendar Year 2026 – two point two five percent (2.25%)
- Calendar Year 2027 – two point two five percent (2.25%)

Contractor may be eligible to receive some or all of the withheld funds based on Contractor's performance in the areas outlined in Section B.3 of this Exhibit. The State reserves the right to adjust performance measures and targets in future Contract years.

3. Calendar Year 2022 Outcome Measures and Incentive Payment Structure

The outcome measures, targets and incentive payment opportunities for calendar year 2022 are set forth below. The performance measures and targets are based on the priority areas established by FSSA. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. Note that if a performance measure is retired during the course of a year, the State, at its sole discretion and in consultation with the Contractor, may replace the performance measure for that performance period. The performance measures and targets applicable during subsequent years of the Contract shall be established annually by FSSA and reflected in an amendment to the Contract.

Contractor performance shall be calculated based on care delivered during calendar year 2022. The State reserves the right to make incentive payments, for any measure, be conditioned upon Contractor substantially maintaining or improving Contractor's outcome on that individual

measure from the previous year. If the State exercises this right, the Contractor will be eligible for incentive payments if Contractor outcomes on individual measures for a certain year decline from the previous year's outcomes by a de minimis amount defined by FSSA for each measure. Future incentive payments for any measure may be conditioned upon Contractor maintaining or improving Contractor's outcome from the prior year.

Measures will be paid based on custom specifications and performance will be determined by FSSA or its designee. Contractor shall submit information to FSSA, in the format and detail specified by FSSA, with respect to each performance measure set forth below. Any data received after the required submission date will not be eligible for an incentive payment.

Incentive payments are payable in the form of release of funds withheld. For purposes of this subsection only, the amount withheld shall be referred to as the "Performance Withhold." The amount of the Performance Withhold at risk varies by measure.

i. ***Completion of Initial Health Needs Screening.*** Administrative reporting, based on Contractor reported data, for completion of initial health needs screening required during member's first ninety (90) days of enrollment with the Contractor. During the measurement year, this measure shall be defined as the percentage of initial health needs screenings completed, excluding terminated members.

Amount of Performance Withhold at Risk: *Twenty percent* (15%)

If Contractor's 2022 measurement rate is at or above fifty-five percent (55%) screened and below sixty percent (60%) screened, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement rate is at or above sixty percent (60%) screened and below sixty-five percent (65%) screened, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement rate is at or above sixty-five percent (65%) screened, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

Standard for Year over Year Performance Changes:

Contractor will receive its incentive payment based on measurement year rate regardless of prior year performance.

ii. ***Completion of Comprehensive Health Assessment.*** Administrative reporting, based on Contractor reported data, for completion of comprehensive health assessment required during the first one hundred and fifty (150) days of enrollment with the Contractor for any member initially stratified into complex case management or the Right Choice Program (RCP) following the initial screening. During the measurement year, this measure shall be defined as the percentage of comprehensive health assessments completed, excluding terminated members.

Amount of Performance Withhold at Risk: *Fifteen percent* (15%)

If Contractor's 2022 measurement rate is at or above seventy-three percent (73%) assessed and below seventy-six percent (76%) assessed, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement rate is at or above seventy-six percent (76%) assessed and below seventy-nine percent (79%) assessed, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement rate is at or above seventy-nine percent (79%) assessed, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

Standard for Year over Year Performance Changes:

Contractor will receive its incentive payment based on measurement year rate regardless of prior year performance.

iii. Annual Dental Visit. Rate of members two (2) to twenty (20) years of age who had at least one (1) dental visit during the year. HEDIS ADV specifications available during the measurement year will be followed for performance measurement.

Amount of Performance Withhold at Risk: Fifteen percent (15%)

If Contractor's 2022 measurement year rate is at or above the twenty-fifth (25th) percentile and below the fiftieth (50th) percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate is at or above the fiftieth (50th) percentile and below the seventy-fifth (75th) percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate is at or above the seventy-fifth (75th) percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

Standard for Year over Year Performance Changes:

Contractor will receive its incentive payment based on measurement year rate regardless of prior year performance.

iv. ***Adult Preventive Care.*** Percentage of members twenty (20) years and older who had a preventive care visit. HEDIS measure (HEDIS AAP) using administrative data.

Amount of Performance Withhold at risk: Fifteen percent (15%)

If Contractor's 2022 measurement year rate is at or above the twenty-fifth (25th) percentile and below the fiftieth (50th) percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate is at or above the fiftieth (50th) percentile and below the seventy-fifth (75th) percentile of the NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate is at or above the seventy-fifth (75th) percentile of the NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

Standard for Year over Year Performance Changes:

Contractor will receive its incentive payment based on measurement year rate regardless of prior year performance.

v. ***Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA).*** Percentage of emergency department (ED) visits for members thirteen (13) years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within seven (7) days of the ED visit (eight (8) total days). HEDIS measure (HEDIS FUA) using administrative data.

Amount of Performance Withhold at risk: Ten percent (10%)

If Contractor's 2022 measurement year rate is at or above the 25th percentile and below the 50th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate is at or above the 50th percentile and below the 75th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate is at or above the 75th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

vi. ***Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA).*** Percentage of emergency department (ED) visits for members thirteen (13) years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within thirty (30) days of the ED visit (thirty-one (31) total days). HEDIS measure (HEDIS FUA) using administrative data.

Amount of Performance Withhold at risk: Ten percent (10%)

If Contractor's 2022 measurement year rate is at or above the 25th percentile and below the 50th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate is at or above the 50th percentile and below the 75thth percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate is at or above the 75th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

vii. ***Increase in COVID-19 Vaccination Rate.*** Percentage of enrolled MCE members eligible for vaccination, ages five and up, net of terminated members, that have met the criteria for COVID-19 fully vaccinated status on December 31, 2022. Age eligibility determination includes members who have reached age 5 and up by September 30, 2022. Final calculation will be performed January 31, 2023.

Fully vaccinated for COVID-19 defined as a member's receipt of either one of Johnson & Johnson, two of Moderna or Pfizer-BioNTech (Comirnaty) COVID-19 vaccines, or vaccines listed by the FDA for emergency use (in accordance with CDC guidelines). Administrative reporting for completion of fully vaccinated status is based on data received from the Indiana Department of Health CHIRP COVID-19 Managed Care Entity Report with the numerator being eligible vaccinated membership as of January 1, 2022, and the denominator being eligible membership as of January 1, 2022, (all eligible except Terminated) to be determined for baseline percentage.

Amount of Performance Withhold at risk: Twenty percent (20%)

If Contractor's 2022 measurement year rate increases an additional twenty-five (25) percentage points from average baseline percentage or meets an average of fifty percent (50%) of eligible membership fully vaccinated (ages 5 and up). Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate increases an additional thirty-five (35) percentage points from average baseline percentage or meets an average of sixty percent (60%) of eligible membership fully vaccinated (ages 5 and up). Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.

If Contractor's 2022 measurement year rate increases an additional forty-five (45) percentage points from average baseline percentage or meets an average of seventy percent (70%) of eligible membership fully vaccinated (ages 5 and up). Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

OMPP Expectations:

The COVID-19 Vaccination Improvement Process ensures the Indiana Medicaid population receives COVID-19 vaccination to improve health outcomes by promoting disease prevention efforts aimed at fighting against the spread of coronavirus (2019-nCoV).

1. MCEs will use internal data review practices to identify unvaccinated, eligible members and implement initiatives that focus on vaccination to this population.

2. MCEs should develop quality assurance processes to ensure the accurate reporting and submission of vaccination data.

3. MCEs will use recommended best practices based on literature review to address cultural barriers and vaccine hesitancy, to promote on the ground community vaccine outreach, and to align initiatives with CMS call to action response.

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EXHIBIT 2.A.
CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Overview:

Age:

- Eligible age group is defined as five years and up.
- Final calculation is age eligibility as of September 30, 2022, of the measurement year.

Fully vaccinated status is determined by:

- One of Johnson & Johnson, OR,
- Two of Moderna or Pfizer (Comirnaty) vaccines, OR
- Vaccines listed by the FDA for emergency use (in accordance with CDC guidelines)

Vaccination status:

- Data derived from Indiana Department of Health CHIRP COVID-19 Managed Care Entity Report
- Calculations will be performed January 31, 2023, to allow reasonable processing of CHIRP entries.

Baseline percentage is calculated:

- Baseline percentage is defined by total number of enrolled, fully vaccinated eligible age groups divided by total number of ALL enrolled eligible age groups.
- Determined on January 1, 2022.

Total percentage points increase of vaccinated members:

- Measurement year rate increases an additional twenty-five (25) percentage points from average baseline percentage *or* meets an average of fifty percent (50%) of eligible membership fully vaccinated, compared to as originally calculated on January 1, 2022, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.
- Measurement year rate increases an additional thirty-five (35) percentage points from average baseline percentage *or* meets an average of sixty percent (60%) of eligible membership fully vaccinated, compared to as originally calculated on January 1, 2022, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.
- Measurement year rate increases an additional forty-five (45) percentage points from average baseline percentage *or* meets an average of seventy percent (70%) of eligible membership fully vaccinated, compared to as originally calculated on January 1, 2022, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

4. Timing of Payments

FSSA will make its best efforts to distribute a report identifying Contractor's performance for the previous calendar year before the end of the current calendar year and the amount of incentive payments, if any, earned for such year for each outcome measure identified in Section B.3. FSSA will make its best efforts to distribute payment to Contractor, subject to Section B.5 below, by December 31 of each year.

5. Conditions to Incentive Payments

FSSA will not have any obligation to distribute the Contractor's incentive payment to Contractor if FSSA has made a determination that Contractor is not eligible to participate in the pay for outcomes program, as described in Section B.1. The State encourages plans to share earned incentive payments with members and providers.

6. Disposition of Undistributed Incentive Payment Funds

In the event the maximum amount of the incentive payment funds available to all managed care plan contractors is not earned and distributed based on the performance of Contractor and/or other managed care plan contractors, FSSA will retain the difference (hereinafter referred to as the "undistributed incentive payment funds"). The undistributed incentive payment funds, which may include unearned withhold funds forfeited by other managed care plan contractors, may be available to Contractor to fund all or a portion of quality improvement initiatives proposed by Contractor, subject to the conditions set forth by OMPP for priorities described in the OMPP Quality Strategy Plan. Such quality improvement initiatives may include, but are not limited to, healthcare IT initiatives such as electronic health records, e-prescribing and/or data sharing with health information exchanges; cost and quality transparency initiatives; number of provider and member complaints handled; overall HEDIS scores; PMP access; behavioral health and physical health initiatives; timeliness of claims payment; clinical outcomes and clinical initiatives.

The Director of the Office of Medicaid Policy and Planning must approve requests for any initiatives proposed to earn undistributed incentive payment funds.
FSSA has full discretion to determine whether and the extent to which any such distributions will be made and the FSSA may choose not to award undistributed incentive payment funds.

7. Non-Financial Incentives

In addition to the potential to earn incentive payments based on performance in the identified areas, FSSA may establish other means to incent performance improvement.

FSSA retains the right to publicly report Contractor performance. Information which may be provided in public reports includes but is not limited to Contractor's audited HEDIS report, Contractor's Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, and information based on Encounter Data Quality submissions or underlying encounter data submitted by Contractor. FSSA intends to distribute information on key performance indicators to participating managed care plan contractors and the public on a regular basis, identifying Contractor's performance, and comparing that performance to other managed care plan contractors, standards set by FSSA and/or external benchmarks or industry standards. FSSA may recognize managed care plan contractors that attain superior performance and/or improvement by publicizing their achievements. For example, FSSA may post information concerning exceptional performance on its website, where it will be available to both

stakeholders and members of the public. To the extent data is used in a public report, it must be received by stated deadline in order to be published.

In year two (2) of the Contract, FSSA intends to include Contractor quality and performance indicators on materials distributed to potential members to facilitate MCE selection. The State reserves the right to develop a rating system advertising Contractor performance on areas such as consumer satisfaction, network access and quality improvement.

Following the initial year of the Contract, after which sufficient quality data is anticipated to be available, the State seeks to reward high performing MCEs through the auto-assignment logic. For example, in developing the auto-assignment methodology, the State reserves the right to consider factors such as Contractor performance on clinical quality outcomes as reported through HEDIS data, enrollee satisfaction as delineated through the CAHPS survey results, network access and other outcome measures.

1.0 Overview of the Program

Medicaid is a federal-and state-funded health care program providing reimbursement for reasonable and necessary medical care for persons meeting eligibility requirements. The Indiana

Family and Social Services Administration (FSSA) administers the Hoosier Care Connect program in Indiana. More detailed information about Indiana Health Coverage Programs (IHCP) is available on the State's website at http://www.indianamedicaid.com/.

2.0 Eligible and Excluded Populations

The State has sole authority for determining whether individuals meet the eligibility criteria of the Hoosier Care Connect program. The FSSA Division of Family Resources (DFR) makes eligibility determinations.

Individuals in the following aid categories who are not enrolled in Medicare, do not have a level of care and do not fall into one of the excluded groups detailed below are enrolled with a Managed Care Entity (MCE) in the Hoosier Care Connect program:

- Aged individuals (MA A);
- Blind individuals (MA B);
- Disabled individuals (MA D);
- Individuals receiving Supplemental Security Income (SSI) (MASI); and
- M.E.D. Works enrollees (MADW, MADI).

Individuals in the following aid categories may voluntarily enroll in Hoosier Care Connect through an opt-in process:

- Children receiving adoption assistance (MA 8);
- Foster children (MA 4);
- Former Foster Care (age 18-21) (MA 14); and
- Former Foster Children (enrolled as of 18th birthday, age 18-26) (MA 15).

Individuals who are American Indians/Alaskan Natives, as verified by the DFR, in any of the Hoosier Care Connect eligible categories may voluntarily enroll in the program through an opt-out process.

The following Indiana Medicaid enrollees are excluded from participation in Hoosier Care Connect managed care:

- Undocumented persons eligible for Emergency services only;
- Individuals enrolled in a 1915(c) home and community-based services (HCBS) waiver;
- Individuals dually eligible for Medicare and Medicaid;

- Persons in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and state operated facilities;
- Individuals receiving room and board assistance;
- Individuals with a nursing home level of care;
- Individuals with a psychiatric residential treatment facility (PRTF) level of care;
- Individuals enrolled in the Hoosier Healthwise or Healthy Indiana Plan (HIP) programs;
- Individuals enrolled in the Family Planning Eligibility Program;
- Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII) of the Social Security Act;
- Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
- Refugee Medical Assistance;
- Money Follows the Person Grant enrollees; and
- Residential Care Assistance Program (RCAP) enrollees.

3.0 Delivery System

MCEs, which include both Indiana-licensed accident and sickness insurers and health maintenance organizations (HMOs), contract with FSSA to provide covered services to Hoosier Care Connect enrolled members. The MCEs manage care through a contracted network of providers.

The State requires MCEs to initiate network development. The State will evaluate the Contractor's progress in its network development efforts prior to the start date of the Contract. Contract Exhibit 1, Scope of Work describes the network requirements in further detail. FSSA reserves the right to limit the enrollment, by county, of a particular MCE, in order to ensure members have adequate choice of plans.

4.0 Covered Services

Hoosier Care Connect enrollees receive full Medicaid benefits. Medicaid covered services are outlined in 405 IAC 5. Table 1 provides a general summary of the Medicaid covered services and limitations and identifies whether each service is reimbursed by the Contractor. Contract **EXHIBIT 1, SCOPE OF WORK** describes the benefits and services in greater detail, including, but not limited to, the following:

- Medicaid services covered under the Hoosier Care Connect program.
- Self-referral services.
- Carved-out services including Medicaid Rehabilitation Option (MRO) services, 1915(i) State Plan home and community-based services, individualized family services plans and

individualized education plans, including those services exclusively provided under the First Steps program. These services are reimbursed by Indiana Medicaid on a fee-for-service basis.

- Medicaid services excluded from Hoosier Care Connect include long-term nursing home care, psychiatric treatment in a state hospital, psychiatric residential treatment facility (PRTF) services, HCBS waivers and ICF/IIDs. Individuals receiving these services will be disenrolled from the Contractor, with the exception of PRTF services for which the enrollee will have their MCE enrollment suspended.

- Non-covered services are those services identified in 405 IAC 5 as being non-covered, including the list of non-covered services set forth in 405 IAC 5-29-1.

- When members are subject to copayment requirements and must be charged copayments for MCE-covered services.

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TABLE 2: HOOSIER CARE CONNECT BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Adult Mental Health and Habilitation (AMHH) – 1915(i) (405 IAC 5-21.6)	NO	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Services include: • Adult day services; • HCB habilitation; • Respite • Therapy and behavioral support services; • Addiction counseling; • Peer support services; • Supported community engagement services; • Care coordination; and • Medication training and support.
Behavioral and Primary Healthcare Coordination (BPHC) – 1915(i) (405 IAC 5-21.8)	NO	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Includes coordination of healthcare services to manage the healthcare needs of the recipient including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case and linkage to appropriate services. Limited to forty-eight (48) units per six (6) months.

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required
[2] Services not reimbursed through Hoosier Care Connect are covered (available) and reimbursed for members under traditional Medicaid benefits reimbursement.

EXHIBIT 3.A.
PROGRAM DESCRIPTION AND COVERED BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Care Conferences	YES	Coverage of procedure code 99211 with the SC modifier for HCC care conferences, payment of $40 reimbursement to the provider.
Children's Mental Health Wraparound (CMHW) – 1915(i) (405 IAC 5-21.7)	NO	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Services include: • Family support and training; • Habilitation; • Respite; and • Wraparound facilitation.
Chiropractors* (405 IAC 5-12)	YES (Self-referral)	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five (5) visits and fifty (50) therapeutic physical medicine treatments per member per year.

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Dental Services (405 IAC 5-14)	YES	Coverage for medically necessary, covered dental services with no annual dollar limit applied. Reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs and emergency treatment. Full mouth series or panorex are limited to one (1) set per recipient every three (3) years, one (1) set per recipient every twelve (12) months for bitewing radiographs. Comprehensive detailed oral evaluation is limited to one (1) per lifetime, per recipient, per provider, with an annual limit of two (2) per recipient. A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient. Topical fluoride is not covered for recipients twenty-one (21) years of age or older. Prophylaxis is limited to one (1) unit every (6) months for non-institutionalized children ages twelve (12) months up to their twenty-first birthday and one unit every twelve (12) months for non-institutionalized recipients over age (21). Periodontal surgery is a covered service only for cases of drug-induced periodontal hyperplasia. Payment for office visits is not covered; reimbursement is only available for covered services actually performed. In accordance with Federal law, all medically necessary dental services are provided for children under age twenty-one (21) even if the service is not otherwise covered.
Diabetes Self-Management Training Services* (405 IAC 5-36)	YES	Limited to sixteen (16) units per member per year. Additional units may be prior authorized.

EXHIBIT 3.A.
PROGRAM DESCRIPTION AND COVERED BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Legend Drugs (405 IAC 5-24)	YES	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid. The following drugs are carved out of the HCC capitation rates for CY 2021 (full rating period): • Hepatitis C drugs (GPI 125350 or 123599) • Hemophilia Agents (GPI 8510) • Spinal Muscular Atrophy Treatments (GPI 7470) • Muscular Dystrophy Treatments (GPI 7460) • CAR-T Therapies (GPI 21651010 and 21651075) • Durable Genetic Therapy (GPI 8637) • Cystic Fibrosis Agents (GPI 453020 and 453099) • Sickle Cell Agents (GPI 828050 and 828070) • FDA approved SARS Coronavirus Vaccines and Administration
Non-legend Drugs (405 IAC 5-24)	YES	Medicaid covers non-legend (over-the-counter) drugs on its formulary. This is available via a link from the IHCP website at https://inm.providerportal.catamaranrx.com/providerportal/faces/PreLogin.jsp
Early Intervention Services (Early Periodic Screening, Diagnosis and Treatment [EPSDT]) (405 IAC 5-15)	YES	Covers comprehensive health and developmental history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary health care services in accordance with the IHCP Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch Provider Reference Module.
Emergency Services (IC 12-15-12-15 & 12-15-12-17)	YES (Self-referral)	Emergency services are covered subject to the prudent layperson standard of an Emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an Emergency medical condition are covered.

EXHIBIT 3.A.
PROGRAM DESCRIPTION AND COVERED BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Eye Care, Eyeglasses and Vision Services (405 IAC 5-23)	YES (Self-referral)	Coverage for the initial vision care examination will be limited to one (1) examination per year for a member under twenty-one (21) years of age and one (1) examination every two (2) years for a recipient twenty-one (21) years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one (1) pair per year for members under twenty-one (21) years of age and one (1) pair every five (5) years for members twenty-one (21) years and older.
Family Planning Services and Supplies	YES (Self-referral)	Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines.
Federally Qualified Health Centers (FQHCs) (405 IAC 5-16-5)	YES	Coverage is available for medically necessary services provided by licensed health care practitioners.
Food Supplements, Nutritional Supplements, and Infant Formulas** (405 IAC 5-24-9)	YES	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.
Hospital Services Inpatient* (405 IAC 5-17)	YES	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Hospital Services Outpatient* (405 IAC 5-17)	YES	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

EXHIBIT 3.A.
PROGRAM DESCRIPTION AND COVERED BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Home Health Services** (405 IAC 5-16)	YES	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.
Hospice Care** (405 IAC 5-34)	YES (including hospice in an institutional setting)	Hospice is available under Medicaid if the recipient is expected to die from illness within six (6) months. Coverage is available for two (2) consecutive periods of ninety (90) calendar days followed by an unlimited number of periods of sixty (60) calendar days.
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) ** (405 IAC 5-13-2)	NO (responsible for up to 60 days while the LOC determination is pending)	Sixty (60) days maximum, pending and prior to level of care determination. Medicaid coverage is available with preadmission diagnosis and evaluation. Includes room and board; mental health services; dental services; therapy and habilitation services; durable medical equipment; medical supplies; pharmaceutical products; transportation; optometric services. Member must be disenrolled from Hoosier Care Connect for the benefit to begin.
Laboratory and Radiology Services (405 IAC 5-18; 405 IAC 5-27)	YES	Services must be ordered by a physician or other practitioner authorized to do so under state law.
Long Term Acute Care Hospitalization	YES	Long term acute care services are covered. Prior authorization is required. An all-inclusive per diem rate is paid based on level of care.

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)** (405 IAC 5-19)	YES	Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.
Mental health/Behavioral health services-Inpatient (State Psychiatric Hospital)** (405 IAC 5-20-1)	NO	Hoosier Care Connect members are disenrolled from the Contractor when admitted to a State psychiatric hospital.
Mental health/Behavioral health services-Inpatient** (405 IAC 5-20)	YES	Covered.
Mental health/ Behavioral health services-Outpatient (405 IAC 5-20-8)	YES, except MRO services	Coverage includes partial hospitalization services, Clinic Option services, mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Prior authorization is required for services that exceed twenty (20) units, per recipient, per provider, per rolling twelve (12) months.

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Medicaid Rehabilitation Option (MRO) - Community Mental Health Centers (405 IAC 5-21)	NO	Services provided by community mental health centers (CMHCs). Service packages are assigned based on level of need, as determined by an individualized assessment conducted by CMHCs, and qualifying behavioral health diagnosis. Additional units can be prior authorized when determined medically necessary. Services include: • Adult intensive rehabilitation services (AIRS) addition counseling; • Addiction counseling; • Behavioral health counseling and therapy; • Behavioral health level of need redetermination; • MRO case management; • CAIRS; • Medication training and support; • Psychiatric assessment and intervention; and • Skills training and development.
Nurse-midwife services (405 IAC 5-22-3)	YES	Coverage is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse Practitioners (405 IAC 5-22-4)	YES	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Nursing Facility Services (Long-term)** (405 IAC 5-31-1)	NO (responsible for up to 60 days while the LOC determination is pending)	Requires pre-admission screening for level of care determination and disenrollment from Hoosier Care Connect. Coverage includes room and board; nursing care; medical and nonmedical supplies and equipment; durable medical equipment; medically necessary and reasonable therapy services; transportation to vocational/habilitation service programs.
Nursing Facility Services (Short-term) (405 IAC 5-31-1)	YES	The MCE may obtain services for its members in a nursing facility setting on a short-term basis, i.e., for fewer than thirty (30) calendar days. This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. The MCE can negotiate rates for reimbursing the nursing facilities for these short-term stays.
Occupational Therapy** (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct on-site supervision of a registered occupational therapist. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. Prior authorization is not required for initial evaluations, services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation. General strengthening exercise programs for recuperative purposes are not covered by Medicaid. Passive range of motion services as the only or primary modality of therapy and occupational therapy psychiatric services are not covered by Medicaid. Therapy for rehabilitative services will be covered for a recipient no longer than two (2) years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy.

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Organ Transplants (405 IAC 5-3-13)	YES	Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike. Prior authorization is required.
Orthodontics**	YES	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.
Out-of-state Medical Services** (405 IAC 5-5)	YES	Medicaid reimbursement is available for the following services provided outside Indiana: acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies; hospice services, subject to the conditions in 405 IAC 5-34-3; and diagnostic services, including genetic testing. All out-of-state services are subject to the same limitations as in state services. Prior authorization is required except for Emergency services (however, continuing inpatient treatment and hospitalization does require prior authorization). Services may be obtained in the following designated out-of-state cities subject to the prior authorization requirements for in-state services: Louisville, Kentucky; Cincinnati, Ohio; Harrison, Ohio; Hamilton, Ohio; Oxford, Ohio; Sturgis, Michigan; Watseka, Illinois; Danville, Illinois; and Owensboro, Kentucky. Recipients may obtain services in Chicago, Illinois if the recipient's physician determines the service is medically necessary, transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient's family, the service is not available in the immediate area, the recipient's physician complies with all of the criteria set forth in accordance with the state plan and 42 CFR 456.3. Prior authorization will not be approved for the following out of state services: nursing facilities, ICFs/IID, or home health agency services; or any other type of long-term care facility, including facilities directly associated with or part of an acute general hospital.
Physicians' Surgical and Medical Services* (405 IAC 5-25)	YES	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of thirty (30) per calendar year per member per provider without prior authorization. New patient office visits are limited to one (1) per recipient, per provider within the last three (3) years.

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Physical Therapy** (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge, and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Podiatrists (405 IAC 5-26)	YES (Self-referral)	Reimbursement provided for podiatric services performed within the scope of the practice of the podiatric profession. Services covered shall include diagnosis of foot disorders and mechanical, medical, or surgical treatment of these disorders. Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than six (6) routine foot care visits per year are covered for patients with a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous; and has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet. Proof must be submitted of patient visit to a medical doctor or doctor of osteopathy for treatment or evaluation of the systemic disease during the six (6) month period prior to the rendering of routine foot care services. Prior Authorization is required for inpatient hospital stays, corrective footwear for patients under age twenty-one (21) and fitting or supplying of orthopedic shoes for patients with severe diabetic foot disease.
Psychiatric Residential Treatment Facility (PRTF) (405 IAC 5-20-3.1)	NO (Member's MCE enrollment will be suspended)	Reimbursement is available for medically necessary services provided to children younger than twenty-one (21) years old in a PRTF. Reimbursement is also available for children younger than twenty-two (22) years old who began receiving PRTF services immediately before their twenty-first (21st) birthday. All services require prior authorization.

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Rehabilitative Unit Services - Inpatient** (405 IAC 5-32)	YES	The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function or self-care activities.
Residential Substance Use Disorder (SUD) Services	YES	Prior authorization (PA) is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria: • ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services • ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services
Respiratory Therapy* (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, Emergency, and oxygen equipment and supplies necessary for the delivery of oxygen, therapy within thirty (30) calendar days (up to thirty (30) units) following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Rural Health Clinics (405 IAC 5-16-5)	YES	Coverage is available for services provided by a physician, physician assistant nurse practitioner, a clinical psychologist or a clinical social worker. Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those clinics that are located in an area that has a shortage of home health agencies as determined by Medicaid.

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Smoking Cessation and Tobacco Dependence Treatment Services (405 IAC 5-37)	YES	Treatment may include prescription of any combination of smoking cessation and tobacco dependence treatment products and counseling. Providers can prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment. Providers must order tobacco dependence treatment services for the IHCP to reimburse for the services. Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself. The IHCP does not require prior authorization for reimbursement for smoking cessation and tobacco dependence treatment products or counseling. The IHCP reimburses pharmacy providers for smoking cessation and tobacco dependence treatment products, including over-the counter products, only when a licensed practitioner prescribes them for a member, including utilization of the statewide standing order for tobacco cessation products. Only patients who agree to participate in tobacco dependence counseling may receive prescriptions for tobacco dependence treatment products. The prescribing practitioner may want to have the patient sign a commitment to establish a "quit date" and to participate in counseling as the first step in tobacco dependence treatment. A prescription for such products serves as documentation that the prescribing practitioner has obtained assurance from the patient that counseling will occur concurrently with the receipt of tobacco dependence drug treatment. Providers must perform tobacco dependence counseling for a minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) within the course of treatment. IHCP coverage of tobacco dependence counseling services is limited to a maximum of 10 units of counseling per member per calendar year.

EXHIBIT 3.A.
PROGRAM DESCRIPTION AND COVERED BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Speech, Hearing and Language Disorders* (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by physician prior to discharge, or following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Transportation - Emergency* (405 IAC 5-30)	YES	Coverage has no limit or prior authorization requirement for Emergency ambulance or trips to/from hospital for inpatient admission/discharge, transportation for patients on renal dialysis or those residing in nursing homes, accompanying parent or recipient attendant (or both) or for a return trip from the emergency room in an ambulance, if use of ambulance is medically necessary for the transport.
Transportation – Non-emergency medical (405 IAC 5-30)	YES	Non-emergency medical travel is available when another alternative is not available.

EXHIBIT 5.A.
CAPITATION RATES

Hoosier Care Connect Capitation Rates

Actuarial Certification:
The actuarial certification for each Contract year is incorporated in this Contract by reference. Actuarial certifications or amendments to certifications that have been signed by contracted entities and approved by CMS will be considered binding on all parties. As a matter of convenience, rates and other information from the certification are reproduced in this section of the Contract, but the certifications generally contain additional detail that should also be considered a part of this Contract.

Note on Capitation Rates:
The capitation rates listed in this exhibit shall apply for the rating periods April 1, 2021 through December 31, 2022.

Note on Rate Adjustment:
To the extent covered benefits or State-directed fee schedules are adjusted, capitation rates will be subject to revision in order to reflect the required program change. Future capitation rates will also be adjusted each year to reflect new base year data.

From time to time the State may adjust other fee schedules related to covered services for which reimbursement is not State-directed, as defined in 42 CFR 438.6(c)(iii), under this Contract. Where reimbursement is not State-directed, the Contractor may negotiate separate and distinct reimbursement with service providers, constrained only by other Contract provisions, such as access requirements. Should the State change these other fee schedules, there will be no related capitation rate adjustment.

Notes on Risk and Acuity Adjustment:
Each Contractor's rates are risk-adjusted based on the morbidity of their enrolled members, using either risk or acuity adjustment for each contract year. For years in which risk adjustment is employed, total payments by FSSA will be cost neutral, meaning Contractors' rates will be adjusted both up and down, according to the morbidity of their enrolled members relative to all enrolled members.

FSSA reserves the right to change risk adjustment models and tools. FSSA reserves the right to adjust rates retrospectively. Members enrolled for less than six (6) months will be risk adjusted according to each Contractor's average risk adjustment factor.

Note on Retroactive Acuity Adjustment:
The Contractor's 2021 and 2022 capitation rates shall be adjusted using a non-cost neutral retroactive acuity adjustment. This replaces the cost neutral risk adjustment process. The State's intent is to mitigate uncertainty regarding changes in member morbidity levels due to the COVID-19 pandemic.

Risk scores will be developed using the Chronic Illness and Disability System and Medicaid Rx (CDPS + MRx), version 6.4, using concurrent weights, custom-developed using program experience. If found to be material, the rates may also be adjusted for duration and/or treatment reduction impacts based on the claims experience.

For 2021 rates – Retroactive Acuity Adjustment
For each rate group, base risk scores will be developed using aggregate calendar year 2019 experience from all contractors, using data from members enrolled as of June 2019. Initial average risk scores stratified by Contractor will be developed with data from each Contractor's members enrolled as of June 2020, using experience from the 12 months prior to the snapshot date. These initial risk scores will be replaced by the final calendar year 2021 risk scores, which will be stratified by Contractor and calculated with data from all members enrolled as of May 2021 (first snapshot date) for the April through July 2021 rates and with data from all members enrolled

as of October 2021 (second snapshot date) for the August through December 2021 rates, using experience from the 12 months prior to each snapshot date. Final 2021 risk scores will represent the average acuity of members enrolled with each Contractor during the rating period. This calculation and adjustment will be made at the sole discretion of the State. Since a new contractor will be entering the HCC program effective April 1, 2021, the State reserves the right to base the final calendar year 2021 risk on enrollment from months other than May 2021 and October 2021 if it is determined that using different months may better represent the average acuity of each Contractor's members enrolled during the full rating period.

For each set of risk scores above, claims run-out will be limited to an equal number of months in order to provide consistency between time periods. The run-out period shall be determined at the sole discretion of the State. Benefit costs developed from the calendar 2019 rate setting base data will be adjusted to reflect the change in morbidity from calendar year 2019 to calendar year 2020 (initial rates) and ultimately calendar year 2021 (final rates).

For 2022 rates – Retroactive Acuity Adjustment
For each rate group, base risk scores will be developed using aggregate calendar year 2019 experience from all contractors, using data from members enrolled as of June 2019. Initial average risk scores stratified by Contractor will be developed with data from each Contractor's members enrolled as of March 2021 using experience from the 12 months prior to the snapshot date. These initial risk scores will be replaced by the final calendar year 2022 risk scores, which will be stratified by Contractor and calculated with data from all members enrolled as of June 2022, using experience from the 12 months prior to the snapshot date. Final 2022 risk scores will represent the average acuity of members enrolled with each Contractor during the rating period. This calculation and adjustment will be made at the sole discretion of the State. The State reserves the right to base the acuity adjustment applied for CY 2022 on enrollment from months other than June 2022, if it is determined that using different months may better represent the average acuity of each Contractor's members enrolled during the full rating period.

For each set of risk scores above, claims run-out will be limited to an equal number of months in order to provide consistency between time periods. The run-out period shall be determined at the sole discretion of the State. Benefit costs developed from the calendar 2019 rate setting base data will be adjusted to reflect the change in morbidity from calendar year 2019 to calendar year 2021 (initial rates) and ultimately calendar year 2022 (final rates).

Note on Incentive Payment Withholding:
The capitation rates listed in this exhibit do not reflect any withhold amounts. FSSA will withhold a portion of the approved capitation payments from the Contractor on the following schedule:

- Year 1, 2021 – one point eight five percent (1.85%)
- Year 2, 2022 – one point eight five percent (1.85%)

The percentage withholding will increase in future Contract years, as listed in Exhibit 2, the Contract Compliance and Pay for Outcomes Contract Exhibit. Withhold payments will be calculated as set forth in Section B of Exhibit 2, and the Contractor may be eligible to receive some or all of the withheld funds based on Contractor's performance in the areas outlined therein.

Note on Risk Corridor:
For calendar years 2021 and 2022 the State is implementing a two-sided risk corridor around the benefit cost portion of per member per month capitation rates. This risk corridor calculation shall be calculated separately for each Contractor, by program and year. The Contractor shall retain at most two percent (2%) of the overall gains or losses. The Contractor is at full risk for the first one point five percent (1.5%) of gains or losses. For gains and losses over one point five percent (1.5%) and up to two point five percent (2.5%) the State and Contractor shall share the risk evenly. Gains or losses above the first two point five percent (2.5%) revert to the State.

EXHIBIT 5.A.
CAPITATION RATES

The targeted benefit cost shall be calculated by the State for each Contractor by program and year. The targeted benefit cost shall be calculated according to the method described in the actuarial certification for each applicable Contract year incorporated in this Contract by reference.

The actual benefit cost incurred by the Contractor shall include all regular medical expenditures in the encounter data. For sub-contracted services, only the amount paid to providers may be included; sub-contracted administrative costs are excluded. Expenditures will be evaluated net of selected costs, including third-party liability, pharmacy supplemental rebates, and net reinsurance recoveries. Benefit costs do not include non-encounterable data.

A reconciliation, to be calculated and finalized at the sole discretion of the State, will compare the actual per member per month benefit cost incurred by the Contractor to the targeted benefit cost, and result in a per member per month amount. The dollar value of the remittance is the product of the per member per month amount and the Contractor's calendar year member months.

The State shall perform an interim reconciliation of the calendar year 2021 risk corridor using claim experience with dates of service from January through June of calendar year 2021, allowing for runout through September 30, 2021. A full reconciliation of calendar year 2021 dates of service will occur using claim experience with runout through September 30, 2022.

The calendar year 2021 risk corridor reconciliation will be calculated based on the full calendar year of experience even though a new contract will begin April 1, 2021.

The calendar year 2022 risk corridor reconciliation schedule will mirror the calendar year 2021 risk corridor reconciliation schedule. The calendar year 2022 risk corridor will use the same methodology for determining the target benefit cost but use the calendar year 2022 capitation rates as a basis. The calendar year 2022 risk corridor will have the same tiered structure and parameters as the calendar year 2021 risk corridor. Actual benefit cost will be defined in the same manner. Timing for the reconciliation will also be similar, with dates advanced one year.

Note on Calendar Year 2021 Capitation Rates

The following rate adjustments are anticipated at a future time, but are not reflected in the capitation rates documented in this section:

- Adjustment to reflect updates made to the State-directed outpatient hospital fee schedule for CY 2021
- Adjustment to reflect any state-directed Hospital Assessment Fee (HAF) fee schedule changes that become effective during CY 2021
- Adjustment to reflect any other changes made to State-directed fee schedules during CY 2021
- Adjustment to reflect policy changes implemented to align prior authorization for certain subsets of drugs during CY 2021
- Adjustment to apply retrospective acuity adjustment based on actual 2021 risk scores

Rates Effective April 1, 2021 to July 31, 2021, Before Adjustment for 1.85% Withhold and After Risk Adjustment

HCC Adult	$ 1,580.09
HCC Child	884.10
HCC Foster	293.35
HCC Dual	743.00

EXHIBIT 5.A.
CAPITATION RATES

Rates Effective August 1, 2021 to December 31, 2021, Before Adjustment for 1.85% Withhold and After Risk Adjustment

HCC Adult	$ 1,511.67
HCC Child	933.58
HCC Foster	292.24
HCC Dual	724.77

Note on Calendar Year 2022 Capitation Rates

The following rate adjustments are anticipated at a future time, but are not reflected in the capitation rates documented in this section:

- Adjustment to reflect updates made to the State-directed outpatient hospital fee schedule for CY 2022
- Adjustment to reflect any State-directed Hospital Assessment Fee (HAF) fee schedule changes that become effective during CY 2022
- Adjustment to reflect any other changes made to State-directed fee schedules during CY 202
- Adjustment to reflect policy changes implemented to align prior authorization for certain subsets of drugs during CY 2022
- Adjustment to apply retrospective acuity adjustment based on actual 2022 risk scores

Rates Effective January 1, 2022 to December 31, 2022, Before Adjustment for 1.85% Withhold and After Risk Adjustment

HCC Adult	$ 1,537.84
HCC Child	934.99
HCC Foster	306.20
HCC Dual	764.11