EXHIBIT 4

EXHIBIT 4 RESPONSIBILITIES OF THE STATE

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1.0 Activities of the State and its Agents

Medicaid is a federal and state-funded health care program providing payment for reasonable and medically necessary care for persons meeting eligibility requirements. Each state administers its own program in accordance with federal requirements. In Indiana, the Indiana Family and Social Services Administration (FSSA) administers the Medicaid program, which includes the [MLTSS Program Name] program.

2.0 Medicaid Application and Eligibility Determination

Individuals who do not receive Supplemental Security Income (SSI) apply for Indiana Medicaid benefits through the Division of Family Resources (DFR) and other authorized enrollment centers. DFR is responsible for determining if persons are eligible for Medicaid in an aid category, or eligibility group, which is enrolled in the [MLTSS Program Name] program. SSI recipients are automatically eligible for Indiana Medicaid coverage without a separate application required to DFR.

[MLTSS Program Name] eligibility redetermination for non-SSI recipients typically occurs every twelve (12) months. Individuals enrolled in [MLTSS Program Name] who are SSI recipients are not required to undergo an annual Medicaid redetermination.

3.0 Member Enrollment and Linkage to an MCE

[MLTSS Program Name] applicants who are not receiving SSI benefits will have an opportunity to select a managed care entity (MCE) on their Medicaid application. Enrollees who do not select an MCE at the time of application, and 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. The Enrollment Broker is also available to assist members in choosing an MCE. The Enrollment Broker will conduct telephonic outreach to the member to facilitate MCE selection. Individuals who do not select an MCE within sixty (60) days of the enrollment mailing will be auto-assigned to an MCE according to the State's auto-assignment methodology.

The State will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, health status or the need for health care services, in accordance with 42 CFR 438.6(d).

3.1 Enrollment Broker Services

The State's Enrollment Broker employs Helpline staff who provides information on the managed care programs over the phone to potential members. The Helpline staff shall educate potential members about the benefits of primary and preventive care, the differences between the MCE options available to the potential member and the importance of choosing a PMP once enrolled in an MCE and establishing the PMP and member relationship. Enrollment education must include, but not necessarily be limited to the items noted below:

- Basic features of managed care
- How to access the Medicaid health care system appropriately (i.e., keeping appointments, appropriate use of the emergency room, prior authorization requirements, understanding MCE rules, how to file a grievance, etc.)
- Where applicable, how to access the transportation benefits within the MCEs rules.
- The importance of primary and preventive care and other health promotion services
- Detailed, unbiased information about the MCEs including provider network, formulary, and enhanced benefits (to be developed in concert with the MCEs and FSSA)
- Information on how and when a member can change their MCE, including education on the MCE grievance process.

- Direction on where to seek help enrolling in a Medicare plan.

3.2 Auto-assignment to MCE

For [MLTSS Program Name] eligible members who do not select an MCE on the application, or within sixty (60) days, the State fiscal agent will auto-assign the individual to an MCE. The rules and logic for auto-assignment are created by the State and comply with 42 CFR 438.52(f). The State maintains an auto-assignment logic which considers established provider relationships and assignment of all family members to the same MCE. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. The State also anticipates establishing a rotating assignment methodology among all MCEs for members who cannot be matched to an MCE based on established provider relationship or family member assignment. In accordance with 42 CFR 438.56(c), the State will automatically re-enroll with the MCE beneficiaries who are disenrolled solely because of the loss of eligibility for a time period of two (2) months or less.

The State maintains eligibility records in the State's eligibility management information database. The State transmits eligibility data daily to the Medicaid management information system (MMIS) and *Core*MMIS. The MMIS system identifies [MLTSS Program Name] eligible members who did not select an MCE on their application and assigns them to an MCE according to the State's auto-assignment methodology.

4.0 Enrollment Rosters

The State fiscal agent notifies each MCE of all members enrolled in the MCE. The State fiscal agent generates MCE Member Enrollment Rosters using information obtained from the DFR's transmissions, and MCE assignments entered into the Indiana MMIS system. The MCE Member Enrollment Rosters provide the MCE with a detailed listing of all members for whom the MCE is or has been responsible and identifies each enrollee's benefit package. The MCE is responsible for reconciling the eligibility rosters with capitation payments received. The State fiscal agent's eligibility verification systems, which are updated daily, must be used in the event of any discrepancies. The MCE discovering eligibility/capitation discrepancies shall notify the fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after the MCE receives the eligibility records.

Refer to the [MLTSS Program Name] MCE Policies and Procedures Manual for detail about the eligibility roster process.

5.0 MCE Member Enrollment Limitations

To ensure member choice of MCEs and availability of healthcare providers, the State will monitor MCE member enrollment in the region monthly. The State reserves the right to monitor the actual panel sizes of each of the MCE's providers. If the determination is made to restrict an MCE's enrollment, the State will notify the MCE in advance of implementing member enrollment limitations. The State may impede MCE member enrollment growth by one or more of the following methods:

- Excluding the MCE from receiving default auto-assignment; or
- Excluding the MCE from receiving previous MCE auto-assignment.

The State will evaluate MCE member enrollment each month to determine when any of the member limitations may be lifted.

6.0 Member Disenrollment from the MCE

[MLTSS Program Name] members are allowed to change MCEs during the sixty (60) day period following their initial enrollment and during the annual plan selection period, to occur in alignment with the Medicare open enrollment window. The member can disenroll from the MCE by contacting the Enrollment Broker and requesting a change in his/her MCE assignment. After the first sixty (60) day period, Members will have the opportunity to change their MCE at the following intervals:

- Within 60 days of starting coverage,
- At any time their Medicare and Medicaid plans become unaligned,
- Once per calendar year for any reason
- At any time using the just cause process (defined below)
- During Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year.

42 CFR 438.56 permits members to request disenrollment from the MCE for just cause at any time. Just cause reasons include:

- 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 MCE's contract with the State.
- Service not covered by the MCE for moral or religious objections.
- Related services required to be performed at the same time and not all related services are available within the MCE's network, and the member's medical provider determines that receiving the services separately would subject the member to unnecessary risk.
- Lack of access to providers experienced in dealing with the member's healthcare needs.
- Member's provider disenrolls from current MCE.
    - If a member's healthcare provider disenrolls from the member's current MCE and re-enrolls in a new MCE, the member can change plans to follow his or her provider to the new MCE.
- Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.

Members must file a grievance with their MCE before a determination will be made upon their just cause request. If the member remains dissatisfied with the outcome, he or she can contact the Enrollment Broker to request disenrollment. The Enrollment Broker reviews the request and makes a disenrollment recommendation. In making the disenrollment recommendation, the Enrollment Broker will review a copy of the member's grievance and appeals record from the MCE, to confirm that the grievance and appeals process was exhausted. All Enrollment Broker reviews which result in a recommendation to approve MCE disenrollment are sent to the State and FSSA makes the final determination on the request.

Additionally, enrollees are permitted to request disenrollment when the State imposes granting this right as an intermediate sanction as specified at 42 CFR 438.702(a)(3). The State shall be responsible for notifying enrollees of these rights.

7.0 Disenrollment from [MLTSS Program Name]

The following are causes for which [MLTSS Program Name] members can be disenrolled from the program:

- The member was enrolled in error or because of a data entry error.
- The member loses eligibility in [MLTSS Program Name]
- The member moves out of State.
- The member passes away.
- An American Indian/Alaskan Native member opts out.

An MCE member may disenroll from an MCE while retaining eligibility in the [MLTSS Program Name] program. Member disenrollment from an MCE with enrollment into another MCE occurs under any of the circumstances listed in Exhibit 4, Section 6.0.

Some instances may warrant a member's disenrollment from the [MLTSS Program Name] managed care program while eligibility is maintained in another Indiana Health Coverage Program's (IHCP) component. It is important to the program's integrity that criteria used to make this determination are valid reasons for disenrollment and are applied consistently for all program enrollees. The Enrollment Broker monitors, tracks, and approves all member disenrollment based on the program's policy for quality improvement. FSSA has the ultimate authority for allowing eligible members to disenroll from the program. Examples of acceptable reasons for member disenrollment from the [MLTSS Program Name] managed care program to participate in another IHCP program include but are not limited to the following:

- The member is determined to be ineligible for managed care under the terms of the State of Indiana 1915(b/c) waiver.
- A change in aid category causes the enrolled member to become ineligible for [MLTSS Program Name].
- The member is admitted to a psychiatric residential treatment facility (PRTF). At admission, a level of care is assigned in Indiana *Core*MMIS and the member is transitioned to fee-for-service.
- The member is admitted to a state psychiatric hospital.

MCEs may not request disenrollment of a member because of an adverse change in the member's health status, the member's utilization of medical services, diminished mental capacity, uncooperative or disruptive behavior resulting from the member's special needs (except when the member's continued enrollment in the MCE seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). FSSA has the ultimate authority for allowing eligible members to disenroll from the program. FSSA and the Enrollment Broker will discourage members from disenrolling or switching plans or programs.

8.0 Provider Enrollment and Disenrollment

The State considers all providers as eligible to participate in [MLTSS Program Name] when the provider enrolls with the IHCP. All [MLTSS Program Name] providers, who in accordance with IHCP policy, are provider types eligible and required to enroll as an IHCP provider, must first be enrolled as IHCP providers before providing services to members. The State allows providers to contract with any number of MCEs.

9.0 Ongoing MCE Monitoring

FSSA reviews and monitors MCE performance on a regular basis and identifies non-compliance

with program requirements and performance standards outlined in the Contract. FSSA conducts monitoring activities through site visits, document review, review of performance data and analysis of encounter claims data. FSSA reserves the right to change or modify the reporting requirements, evaluation instruments and enforcement policies, as necessary, at any time during the Contract period with sufficient notice to the MCEs resulting from its monitoring activities or changes in State or federal requirements.

FSSA, or duly authorized agents of the State or federal government, reserves the right to inspect, audit, monitor or otherwise evaluate the performance of the MCE or its subcontractors during normal business hours, at the MCE's or its subcontractors' premises. At a minimum, FSSA will conduct regular monthly on-site reviews, and these reviews may include an audit of financial or operational systems and data.

In addition, FSSA complies with the external quality review regulations for monitoring managed care organizations set forth in 42 CFR 438.350.

9.1 FSSA's Right to Audit and Monitor

The Contractor acknowledges the State's responsibility for overseeing the administration of healthcare services to Medicaid beneficiaries enrolled in the State of Indiana's [MLTSS Program Name] program. Accordingly, nothing in this Contract shall be construed to limit FSSA's right or ability to audit and monitor the Contractor's performance of duties identified in the Scope of Work (Exhibit 1), as FSSA may audit and monitor Contractor or any subcontractors/vendors of Contractor at any time and in any manner prescribed in this Contract or under applicable law. The FSSA reserves the right to use vendor(s) to perform these functions on behalf of FSSA and the vendor(s), as FSSA's agent, shall not be required to sign separate Confidentiality Agreements, Business Associate Agreements, or any other document prior to obtaining access to Contractor's information unless so required by FSSA. The Contractor and its subcontractors/vendors shall timely respond to any audit or monitoring requests of FSSA and/or its agents. The failure of Contractor to timely, completely, and accurately respond to audit and monitoring requests may result fines or other sanctions being imposed by FSSA as identified in Exhibit 2 Contract Compliance and Pay for Outcomes.

9.2 Evaluating MCE Solvency

The Indiana Department of Insurance maintains the primary responsibility for monitoring the MCE's solvency and monitors the MCE's financial status.

In addition, FSSA monitors the MCE's solvency status in accordance with federal regulations described in 42 CFR 438.116 by requiring the submission of various financial data for review.

10.0 Policies and Procedures Manual

A sample [MLTSS Program Name] MCE Policy and Procedure Manual can be found in the Bidders' Library.

11.0 Reporting Manual

A sample Reporting Manual can be found in the Bidders' Library.

12.0 Making Payments to the MCE

FSSA pays MCEs participating in [MLTSS Program Name] a monthly capitation payment for each enrolled member.