AMENDMENT #13

CONTRACT #0000000000000000000018315

This is an Amendment to the Contract (the "Contract entered into by and between **the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning** (the "State") and **Coordinated Care Corporation Indiana d/b/a Managed Health Services d/b/a MHS** (the "Contractor") dated January 18, 2017.

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

The Contract for providing risk-based managed care services to Medicaid beneficiaries enrolled in the State of Indiana's Healthy Indiana Plan program is hereby amended to updates Exhibits 2.G, 4.E, 6.C, and 10.K.

Exhibit 2.G, which outlines the Scope of Work, is hereby superseded and replaced by **Exhibit 2.H**, which is attached hereto and incorporated herein.

Exhibit 4.E, which outlines the Contract Compliance and Pay for Outcomes, is hereby superseded and replaced by **Exhibit 4.F**, which is attached hereto and incorporated herein.

Exhibit 6.C, which outlines the Program Description and Covered Benefits, is hereby superseded and replaced by **Exhibit 6.D**, which is attached hereto and incorporated herein.

Exhibit 10.K, which lists the State's Capitation Rates for Healthy Indiana Plan, is superseded and replaced by **Exhibit 10.L**, which is attached hereto and incorporated herein.

Funding in the amount of $99,035,589.46 is being added to the total contract amount. Total remuneration under the Contract is not to exceed **$3,986,838,673.37**.

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 Amendment by accessing State of Indiana Supplier Portal using the secure password assigned to me and by electronically submitting this Amendment to the State of Indiana. I understand that my signing and submitting this Amendment in this fashion is the legal equivalent of having placed my handwritten signature on the submitted Amendment and this affirmation. I understand and agree that by electronically signing and submitting this Amendment in this fashion I am affirming to the truth of the information contained therein. I understand that this Amendment 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 Amendment. The parties, having read and understood the foregoing terms of this Amendment, do by their respective signatures dated below agree to the terms thereof.

Coordinated Care Corporation Indiana

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

Title: CEO

Date: 6/1/2021 | 11:43 CDT

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

DocuSigned by:
By:
3C2ABD79A80D498...

Title: Medicaid director

Date: 6/1/2021 | 13:11 EDT

Electronically Approved by: Indiana Office of Technology By: (for) Tracy E. Barnes, Chief Information Officer	Electronically Approved by: Department of Administration By: (for) Lesley A. Crane, 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

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HEALTHY INDIANA PLAN 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 Healthy Indiana Plan (HIP) program. The State is looking to contract on a statewide basis with managed care entities (MCEs) with a demonstrated capacity to actively manage care for a low income population.

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

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

1.0 Background

The Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) manages the HIP program. For purposes of this Scope of Work, the term "FSSA" shall refer to the agency and its divisions, including, but not limited to OMPP. HIP is one of the Medicaid programs that helps over 360,000 Hoosiers.[1] HIP aims to provide comprehensive health care coverage for Hoosier families.

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

The State is particularly interested in contracting with MCEs that can not only perform the administrative functions of a typical insurer, and is also adept at addressing the unique challenges of low income populations and can manage and integrate care along the continuum of health care services. Goals for the HIP program include:

- Improve health outcomes;
- Promote primary and preventive care;
- Foster personal responsibility and healthy lifestyles;
- Assure the appropriate use of health care services;
- Develop informed health care consumers by increasing health literacy and providing price and quality transparency;
- Improve access to health care services;
- Encourage quality, continuity and appropriateness of medical care;
- Deliver coverage cost-effectively;

[1]The enrollment figures provided in this Scope of Work were current as of July 2017. Enrollment in the HIP program may increase or decrease based upon federal policies, program priorities, available funding, etc.

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- Identify Medically Frail members and provide effective disease management, case management and care management programs for those that would benefit from such services;
- Coordinate health and social services;
- Integrate physical and behavioral health services;
- Develop innovative member and provider incentives;
- Use technology to ease administrative burden and help accomplish program goals;
- Develop innovative utilization management techniques that incorporate member and provider education to facilitate the right care, at the right time, in the right location;
- Emphasize communication, training and collaboration with network providers; and
- Engage in provider and member outreach regarding preventive care, wellness and a holistic approach.

The Healthy Indiana Plan (HIP) is a program created to provide health care coverage to low-income adults. Indiana offers HIP members a comprehensive benefit package through a high deductible health plan paired with a personal health care account called a POWER (Personal Wellness and Responsibility) Account. The health plan is subject to a $2,500 deductible and includes “first dollar” coverage for ACA required preventive services. Services considered preventive but not required by the ACA may be provided at $500 first dollar coverage per year. For purposes of clarification, MCEs may cap first dollar preventive services at $500 per year, but shall provide all required ACA preventive services first dollar as required by the ACA. The preventive services benefit is designed to help eliminate barriers to obtaining preventive care. Indiana offers HIP members comprehensive benefits in several benefit packages (HIP Plus, HIP Basic, HIP State Plan, HIP Maternity, and Hospital Presumptive Eligibility) as described in Section 3. A description of the HIP covered services is set forth in Exhibit 6 of the Contract.

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

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

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

Members with income at or below one hundred percent (100%) of the federal poverty level (FPL)[2] who
do not to make monthly POWER account contributions will be placed in the “HIP Basic” plan, a more limited benefit plan. The HIP Basic plan maintains essential benefits, but incorporates reduced benefit coverage and a more limited pharmacy benefit. The HIP Basic plan will require

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

co-payments for all services rather than the monthly POWER account contributions required of the HIP Plus plan. Except in limited circumstances, members with income above 100% FPL will not have access to the HIP Basic plan, but will instead be terminated from the program and may not reenroll for six (6) months. Contractor shall ensure that they follow all program requirements as described in the HIP MCE Policies and Procedures Manual as updated and amended periodically.

Beginning in calendar year 2019, the State and Contractor will begin phasing in the HIP Gateway to Work (GTW) program, which is a community engagement program that seeks to improve HIP members' physical and mental health, overall financial stability, and well-being. The GTW program will promote opportunities, resources, and connections for HIP members to gain or improve their employment situation, seek additional training or education, and increase community engagement through volunteer work. All fully eligible HIP members may participate in the GTW program and will be assigned a GTW Referral Status by the State.

2.0 Managed Care Entity- Contractor Requirements

2.1 State Licensure

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

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

2.2 National Committee for Quality Assurance (NCQA) Accreditation

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

2.3 Administrative and Organizational Structure

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

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

The Contractor shall have in place sufficient administrative and clinical staff and organizational components to comply with all HIP program requirements and standards. The Contractor shall manage the functional linkage of the following major operational areas:

- Administrative and fiscal management

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

2.4 Staffing

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

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

2.4.1 Key Staff

The Contractor shall employ the key staff members listed below. The State requires

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

The Contractor shall have an office in the State of Indiana from which, at a minimum, key staff members physically perform the majority of their daily duties and responsibilities, and a major portion of the Contractor's operations take place. The Contractor shall be responsible for all costs related to securing and maintaining the facility for interim start-up support and the subsequent operational facility.

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 Healthy Indiana Program. FSSA shall have the right to require that the Contractor remove any individual (whether or not key staff) from assignment to the program.

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

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

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

OMPP reserves the right to approve or deny the individuals filling the key staff positions set forth below. OMPP 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 include, but are not limited to:

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

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

Compliance Officer – The Contractor shall employ a Compliance Officer who is accountable to the Contractor's executive leadership and dedicated full-time to the Contractor's Healthy Indiana Plan product line. This individual will be the primary liaison with the State (or its designees) to facilitate communications between OMPP, the State's contractors and the Contractor's executive leadership and staff. This individual shall maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the HIP program. It is the responsibility of the Compliance Officer to coordinate reporting to the State as defined in Section 12 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.

Information Systems (IS) Coordinator – The Contractor shall employ an IS Coordinator who is dedicated full-time to the Contractor's Indiana Medicaid product lines. This individual will oversee the Contractor's HIP information system(s) and serve as a liaison between the Contractor and the State fiscal agent or other FSSA contractors regarding encounter claims submissions, capitation payment, member eligibility, POWER Account administration, enrollment and other data transmission interface and management issues. The IS Coordinator, 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 IS Coordinator is responsible for attendance at all Technical Meetings called by the State. If the IS Coordinator is unable to attend a Technical Meeting, the IS Coordinator shall designate a representative to take his or her place. This representative shall report back to the IS Coordinator on the Technical Meeting's agenda and action items. For more information on the IS program requirements, see Section 11.

Medical Director – The Contractor shall employ the services of a Medical Director who is a licensed Indiana Health Care Provider (IHCP) provider board certified in family medicine or internal medicine. If the Medical Director is not board certified in family medicine, they shall be supported by a clinical team with experience in pediatrics, behavioral health, adult medicine and obstetrics/gynecology. The Medical Director shall be dedicated full-time to the Contractor's Indiana Medicaid product lines. The Medical Director shall oversee the development and implementation of the Contractor's disease management, case management and care management programs; oversee the development of the Contractor's clinical practice guidelines; review any potential quality of care problems; oversee the Contractor's clinical management program and programs that address special needs populations; oversee health screenings and medically frail assessments; serve as the Contractor's medical professional interface with the Contractor's primary medical providers (PMPs) and specialty providers; and direct the Quality 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 work

closely with the Pharmacy Director to ensure compliance with pharmacy-related responsibilities set forth in Section 6.4. The Medical Director shall attend all OMPP quality meetings, including the Quality Strategy Committee meetings. If the Medical Director is unable to attend an OMPP quality meeting, the Medical Director shall designate a representative to take his or her place. Notwithstanding the Medical Director 's sending of a representative, the Medical Director shall be responsible for knowing and taking appropriate action on all agenda and action items from all OMPP quality meetings.

Member Services Manager – The Contractor shall employ a Member Services Manager who is dedicated full-time to member services for the Contractor's Healthy Indiana Plan product line, which shall be available via the member helpline and the member website, including through a member portal. The Member Services Manager shall, at a minimum, be responsible for directing the activities of the Contractor's member services, including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval and distribution of member materials and employer outreach for HIP members. The Member Services Manager manages the member grievances and appeals process, and works closely with other managers (especially, the Quality Manager, Utilization Manager and Medical Director) and departments to address and resolve member grievances and appeals. The Member Services Manager shall oversee the interface with the Enrollment Broker regarding such issues as member enrollment and disenrollment, member PMP assignments and changes, member eligibility and newborn enrollment activities The Member Services Manager shall provide an orientation and on-going training for member services helpline representatives, at a minimum, to support accurately informing members of how the Contractor operates, availability of covered services, benefit plans and limitations, health screenings, emergency services, PMP assignment and changes, specialty provider referrals, self-referral services, preventive and enhanced services, POWER Account services, GTW 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 7.

Provider Services Manager – The Contractor shall employ a Provider Services Manager who is dedicated full-time to the Contractor's Healthy Indiana Plan product. The Provider Services Manager shall, at a minimum, be responsible for the provider services helpline performance, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials and developing outreach programs. The Provider Services Manager oversees the process of providing information to the State fiscal agent regarding the Contractor's provider network, including PMPs, via Provider Healthcare Portal (Portal). 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 8.

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,

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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 Unit. 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 Unit. 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. The SIU Manager shall be required to interview with the OMPP PI Unit prior to obtaining FSSA approval

Quality Improvement Management Manager – The Contractor shall employ a Quality Management Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The Quality Improvement Management Manager shall, at a minimum, be responsible for directing the activities of the Contractor's quality management staff in monitoring and auditing the Contractor's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Quality Improvement Management Manager shall assist the Contractor's Compliance Officer in overseeing the activities of the Contractor's operations to meet the State's goal of providing health care services that improve the health status and health outcomes of HIP members. For more information regarding the quality management requirements, see Section 9.

Utilization Management Manager – The Contractor shall employ a Utilization Management Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The Utilization Management Manager shall, at a minimum, be responsible for directing the activities of the utilization management staff. With direct supervision by the Medical Director, the Utilization Management Manager shall direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, appropriate utilization of health care services, continuity of care, care coordination and other clinical and medical management programs. The Utilization Management Manager shall work with the Special Investigation Unit (SIU) Manager to assure that service billing and utilization issues are documented and reported to the SIU, and matters requiring SIU review or investigation shall be timely submitted within five (5) business days to enable recovery of overpayments or other appropriate action. For more information regarding the utilization management requirements, see Section 9.

Behavioral Health Manager – The Contractor shall employ a Behavioral Health Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The Behavioral Health Manager is responsible for ensuring that the Contractor's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager shall coordinate with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance and reporting. The Behavioral Health Manager shall fully participate in all quality management and improvement activities, including participating in Quality Strategy Committee meetings and in the Mental Health Quality Assurance Committee. The Behavioral Health Manager shall work closely with the Contractor's network development and provider relations staff to develop and maintain the behavioral health network and ensure that it is fully integrated with the physical health provider network. The Behavioral Health Manager shall collaborate with key staff to ensure the coordination of physical and behavioral

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health care as set forth in Section 6.7 and coordination with Medicaid Rehabilitation Option (MRO) and 1915(i) services as set forth in Sections 6.11.1 and 6.11.2. The Behavioral Health Manager shall work closely with the utilization management staff to monitor behavioral health utilization, especially to identify and address potential behavioral health under- or over-utilization. The Behavioral Health Manager or designee shall be the primary liaison with behavioral health community resources, including Community Mental Health Centers (CMHCs), and be responsible for all reporting related to the Contractor's provision of behavioral health services. The Behavioral Health Manager shall work closely with the Medical Director and Transition Coordination Manager to appropriately identify medically frail HIP members and ensure access to appropriate behavioral health services.

If the Contractor subcontracts with a behavioral health organization (BHO) to provide behavioral health services, the Behavioral Health Manager will continue to work closely with the Contractor's other managers to provide monitoring and oversight of the BHO and to ensure the BHO's compliance with the Contract. (See Section 2.7 regarding requirements for OMPP's approval of subcontractors.)

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

Pharmacy Director. The Contractor shall employ a Pharmacy Director who is an Indiana licensed pharmacist dedicated full-time to the Contractor's Indiana Medicaid product lines. The Pharmacy Director shall oversee all pharmacy benefits under this Contract as outlined in Section 6.4. This individual shall represent the Contractor at all meetings of the State's Drug Utilization Review (DUR) Board meetings and the Mental Health Quality Assurance Committee (MHQAC). If the Contractor subcontracts with a Pharmacy Benefits Manager (PBM) for its Healthy Indiana Plan pharmaceutical services, the Pharmacy Director shall be responsible for oversight and Contract compliance of the PBM, including pharmacy audits, as well as any audits or other responses.

POWER Account Operations Manager. The Contractor shall employ a POWER Account Operations Manager who is dedicated full-time to the HIP program's POWER Account operations. The POWER Account Operations Manager shall be responsible for overseeing the accurate and efficient administration of member POWER Accounts, as outlined in the HIP MCE Policies and Procedures Manual, including but not limited to: POWER Account contribution billing, reminders and collections; applying member, state, third party and employer contributions to the POWER Account; member termination or transfer to HIP Basic, as applicable, for non-payment; Power Account Reconciliation files (PRFs); POWER Account statements; POWER Account reconciliation and rollover; POWER Account

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contribution recalculations; POWER Account transfers; and POWER Account reporting. This individual shall be responsible for ensuring compliance with the terms of this Contract and all POWER Account policies and procedures as outlined in the POWER Account technical requirements and the HIP MCE Policies and Procedures Manual.

GTW Operations Manager. The Contractor shall employ a GTW Operations Manager who is dedicated full-time to the HIP program's GTW operations. The GTW Operations Manager shall be responsible for overseeing the accurate and efficient administration of member GTW accounts, as outlined in the HIP MCE Policies and Procedures Manual, including but not limited to: member exemptions and qualifying activities, member compliance assistance, pre-suspension activities, monthly GTW status statements, GTW Assistance Planning, and GTW reporting. This individual shall be responsible for ensuring compliance with the terms of this Contract and all GTW policies and procedures as outlined in the HIP MCE Policies and Procedures Manual.

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

Grievance and Appeals Manager. The Contractor shall employ a dedicated Grievance and Appeals Manager responsible for managing the Contractor's HIP grievance and appeals process. This individual shall be responsible for ensuring compliance with processing timelines and policy and procedure adherence as outlined in Section 7.9. The Grievance and Appeals Manager will ensure the Contractor has appropriate representation and/or provides adequate documentation in the event that a member appeals to the State.

Claims Manager. The Contractor shall employ a Claims Manager dedicated full-time to the Contractor's Indiana Medicaid product lines and responsible for ensuring prompt and accurate provider claims processing in accordance with the terms of the Contract. This individual shall work in collaboration with the IS Coordinator to ensure the timely and accurate submission of encounter data as delineated in Section 11.6.

2.4.2 Staff Positions

In addition to the required key staff described in Section 2.4.1, the Contractor shall employ those additional staff necessary to ensure the Contractor's compliance with the State's performance requirements. Suggested staff may include but are not limited to:

GTW program administration coordination staff necessary to coordinate and administer all aspects of the program for which the Contractor is responsible according to the requirements set forth in this Contract and MCE Policy and

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Procedure Manual.

GTW member service staff to address member questions and concerns related to the Gateway to Work program and to conduct required GTW member communications. Member services staff should have access to real time data on members, including their Gateway to Work Referral Status and reporting on qualified activities. Gateway to Work member services staff shall have the appropriate training and demonstrate full competency before interacting with members.

GTW assistance planning staff to administer assistance planning assessments, develop member assistance plans, and conduct assistance planning outreach.

GTW compliance staff to conduct MCE GTW verifications and monitor the MCE verification process and compliance.

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

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

Quality 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.

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

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

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

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

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

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

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

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

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

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

Transition Coordination staff to support the Transition Coordination Manager in the oversight of all member transitions in and out of the various benefit plans available in the Contractor's Indiana Medicaid programs, as well as in an out of the Contractor's enrollment. The Transition Coordination staff shall be responsible for ensuring continuity of care, member and provider communication, and POWER Account reconciliation through all benefit plan and MCE transfers.

2.4.3 Training

On an ongoing basis, the Contractor shall ensure that each staff person, including members of subcontractors' staff, has appropriate education and experience to fulfill the requirements of their position, as well as ongoing training (e.g., orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, management information systems, training on fraud and abuse and the False Claims Act, HIPPA, HI-TECH, etc.). The Contractor shall ensure that all staff members are trained in the major components of the HIP program. The following staff members shall receive additional training specific to the HIP program and their role:

Utilization management staff shall receive ongoing training regarding

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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.

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

GTW member support staff shall receive GTW training on topics including but not limited to: GTW Referral Status and exemptions, qualifying activities, hours requirements and how to log them, utilization of the GTW member portal, GTW member communications, GTW assistance planning, pre-suspension activities, and State suspension.

The State-developed HIP MCE Policies and Procedures Manual 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. The Contractor shall update its training materials on a regular basis to reflect program changes. The Contractor shall maintain documentation to confirm its internal staff training, curricula, schedules and attendance, and shall provide this information to OMPP upon request and during regular on-site visits. For its utilization management and POWER Account training activities in particular, the Contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by OMPP.

2.4.4 Debarred Individuals

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

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

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

The relationships include directors, officers or partners of the 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, which prohibits affiliations with individuals debarred by Federal agencies, if OMPP finds that the Contractor is in violation of this regulation, OMPP will notify the Secretary of noncompliance and determine if

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this Contract will be terminated.

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

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

2.5 FSSA/OMPP Meeting Requirements

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

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

2.6 Financial Stability

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

FSSA and the Indiana Department of Insurance (IDOI) will monitor the Contractor's financial performance. FSSA will include IDOI findings in their monitoring activities. FSSA shall be copied on required filings with IDOI, and the required filings shall break out financial information for the HIP lines of business separately. The financial performance reporting requirements are listed in Section 12.1 and are further described in the HIP MCE Reporting Manuals, which shall be provided following the Contract award date.

2.6.1 Solvency

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

The Contractor shall comply with the federal requirements for protection against insolvency pursuant to 42 CFR 438.116, which sets solvency standards for managed care entities.

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

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

- Meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity

Also, see Section 2.6.3 below.

2.6.2 Insurance

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

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

2.6.3 Reinsurance

The Contractor shall purchase reinsurance from a commercial reinsurer and shall establish reinsurance agreements meeting the requirements listed below. The Contractor shall submit new policies, renewals or amendments to 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 establish commercial reinsurance agreements with an attachment point greater than $200,000 shall 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 shall 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 are not acceptable.

  - The Contractor shall obtain continuation of coverage insurance

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

- Requirements for Reinsurance Companies
  - The Contractor shall submit documentation that the reinsurer follows the National Association of Insurance Commissioners' (NAIC) Reinsurance Accounting Standards.
  - The Contractor is required to obtain reinsurance from insurance organizations that have Standard and Poor's claims-paying ability ratings of "AA" or higher and a Moody's bond rating of "A1" or higher, unless otherwise approved by OMPP.
- Subcontractors
  - Subcontractors' reinsurance coverage requirements shall be clearly defined in the reinsurance agreement.
  - Subcontractors should be encouraged to obtain their own stop-loss coverage with the above-mentioned terms.
  - If subcontractors do not obtain reinsurance on their own, the Contractor is required to forward appropriate recoveries from stop-loss coverage to applicable subcontractors.

2.6.4 Financial Accounting Requirements

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

In accordance with 42 CFR 455.100-104, which defines ownership and control percentages and requires disclosure thereof, the Contractor shall notify OMPP of any person or corporation with five percent (5%) or more of ownership or controlling interest in the Contractor and shall submit financial statements for these individuals or corporations.

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

Authorized representatives or agents of the State and the federal government shall have access to the Contractor's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times

during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit and/or reproduction. In addition, the Contractor shall file with the State Insurance Commissioner the financial and other information required by the IDOI.

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

The Contractor shall maintain financial records pertaining to the Contract, including all claims records, for three (3) years following the end of the federal fiscal year during which the Contract is terminated, or when all state and federal audits of the Contract have been completed, whichever is later, in accordance with 45 CFR 74.53, which sets retention and access requirements for records. Financial records should address matters of ownership, organization and operation of the Contractor's financial, medical and other record keeping systems. However, accounting records pertaining to the Contract shall be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the Contract if the litigation has not terminated within the three (3)-year period.

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

- Tangible Net Equity (TNE) or Risk Based Capital at balance sheet date
- Cash and Cash Equivalents
- Claims payment, IBNR, reimbursement, fee for service claims, provider contracts by line of business
- Appropriate insurance coverage for medical malpractice, general liability, property, workmen's compensation and fidelity bond, in conformance with state and federal regulations
- Revenue Sufficiency by line of business /group
- Renewal Rates or Proposed Rates by line of business
- Corrective Action Plan Documentation and Implementation
- Financial, Cash Flow and Medical Expense Projections by line of business
- Underwriting Plan and Policy by line of business
- Premium Receivable Analysis by line of business
- Affiliate and Inter-company Receivables

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

- Current Liability Payables by line of business
- Medical Liabilities by line of business
- Copies of any correspondence to and from the IDOI

2.6.5 Reporting Transactions with Parties of Interest

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

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

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

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

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

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

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

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

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

2.6.6 Medical Loss Ratio

In calendar year 2017, the MLR shall be calculated as follows:

On an annual basis the Contractor shall calculate and submit to FSSA its Medical Loss Ratio (MLR), based on standards and forms established by the National Association of Insurance Commissioners (NAIC). A separate MLR shall be calculated for the Contractor's HIP line of business. For the HIP line of business, POWER Account expenditures may be included in both the numerator and denominator of the MLR calculation. The MLR calculations shall be exclusive of any taxes. 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 HIP program shall be calculated separately from other managed care programs.

The Contractor shall maintain, at minimum, a MLR of eighty-seven percent (87%) for its HIP line of business.

The MLR will be calculated exclusive of reimbursement for the health insurance providers' fee (see Section 2.6.7).

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

FSSA shall recoup excess capitation paid to the Contractor in the event that the Contractor's MLR, as calculated by FSSA on an annual basis, is less than eighty-seven percent (87%) for the HIP line of business.

Beginning in calendar year 2018, the MLR shall be calculated as follows:

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The Contractor shall calculate and submit to FSSA its Medical Loss Ratio (MLR). For the HIP line of business, POWER Account expenditures may be included in both the numerator and denominator of the MLR calculation. The calculation must fully comply with 42 CFR 438.8. 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 HIP 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 date 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 eighty-seven percent (87%) for its HIP line of business.

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

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

2.6.7 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 beginning in 2014 ("Annual Fee"). 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 this 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 Service. 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 shall submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor shall also submit the calculated adjustment for the impact of non- deductibility of the Annual Fee attributable specifically to its premiums under this 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 its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

2.7 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, any entity that performs delegated activities related to the Contract and any administrative entities not involved in the actual delivery of medical care.

As specified in Section 4, any entity contracted to administer or host the POWER Accounts for HIP members or to provide any point of sale infrastructure will be considered a subcontractor.

FSSA shall approve all subcontractors and any change in subcontractors or material change to subcontracting arrangements as outplayed in Section 2.10 to subcontracting arrangements. FSSA may waive its right to review subcontracts and material changes to subcontracts. The State encourages the Contractor to subcontract with entities that are located in the State of Indiana.

According to IC 12-15-30-5, subcontracts, including provider agreements, cannot extend beyond the term of the Contract between the Contractor and the State. A reference to this provision and its requirements shall be included in all provider agreements and subcontracts.

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

The Contractor shall provide that all subcontracts with other prepaid health plans, physician hospital-organizations, any other entity that performs delegated activities related to the Contract and any administrative entities not involved in the actual delivery of medical care, indemnify and hold harmless the State of Indiana, its officers and

employees from all claims and suits, including court costs, attorney's fees and other expenses, brought because of injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of the Contractor and/or the subcontractors. This indemnification requirement does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

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

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

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

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

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

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

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

- The Contractor shall have a written agreement in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement

shall be in compliance with all the State of Indiana statutes, and will be subject to the provisions thereof. The subcontract cannot extend beyond the term of the State's Contract with the Contractor.

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

- All subcontractors shall fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract. In addition, all subcontractors shall fulfill the requirements of the Contract (and any relevant amendments) that are appropriate to any service or activity delegated under the subcontract.

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

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

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

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 Exhibit 4, for non-compliance with reporting requirements and performance standards.

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

While the Contractor may choose to subcontract claims processing functions, or portions of those functions, with a state-approved subcontractor, the Contractor shall demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and

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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 11.4. In this example, the definition of "date of receipt" is the date of the claim's receipt at the post office box.

2.8 Confidentiality of Member Medical Records and Other Information

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

2.9 Internet Quorum (IQ) Inquires

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

Failure by the Contractor to provide a timely and satisfactory response to IQ inquiries will subject Contractor to the liquidated damages set forth in Exhibit 4.

2.10 Material Change

A material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of the Contractor's membership or provider network.

Prior to implementing a material change in operation, the Contractor shall submit a request to OMPP for review and approval at least sixty (60) calendar days in advance of the effective date of the change. The request shall contain, at minimum, information regarding the nature of the change, the rationale for the change, and the proposed effective date. Contractor may be required, at the direction of OMPP, to communicate material changes to members or providers at least thirty (30) days prior to the effective date of the change. Any member or provider communication material is subject to the review and approval of OMPP in accordance with Section 7.5.

2.11 Future Program Guidance

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

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HEALTHY INDIANA PLAN SCOPE OF WORK

2.12 Conflict of Interest

The Contractor shall ensure compliance with applicable laws and conflict of interest safeguards in accordance with 42 CFR 438.3(f).

2.13 Capitation Related to a Vacated Program

Effective January 1, 2019, 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 HIP Plan Design and Member Eligibility

The Contractor shall provide all HIP members with a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account. The Power Account operates similarly to a Health Savings Account (HSA), and is used to fund a $2,500 deductible, as more fully described in Section 5 below. The Contractor's HIP membership shall be distributed into various subpopulations based on member eligibility. These subpopulations within HIP will have varying benefits and cost-sharing obligations, and the Contractor shall ensure that its HIP members are placed in the appropriate benefit category, in accordance with the eligibility standards set forth in this Section 3, as well as the additional policies and procedures included in the HIP MCE Policies and Procedures Manual. The Contractor is responsible for ensuring seamless transitions between benefit plans as member eligibility changes, as detailed in Section 6.13. A general description of all HIP benefits are in Section 6.

3.1 HIP Plus

Except in the case of individuals eligible for HIP State Plan benefits described in Section 3.3 or individuals receiving hospital presumptive eligibility benefits described in Section 3.5, all HIP eligible members will initially be defaulted into an enhanced benefit package (HIP Plus). Except for individuals exempt from copayments as set forth in Section 4.1.4, HIP Plus participation requires members to make monthly POWER Account contributions. Member eligibility in HIP Plus shall not be final until either the first POWER Account contribution or fast track prepayment contribution is paid, in accordance with Section 4.7. Except as set forth in Section 4.7.1, to remain eligible for HIP Plus, members shall continually make monthly POWER Account contributions as set forth in Section 4.1.1.

3.1.1 Low Income Adults

Parent/caretaker members determined eligible for transitional medical assistance (TMA) by the State in accordance with Section 1925 of the Social Security Act shall either attain or remain in HIP Plus coverage for up to twelve (12) months during

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their TMA eligibility period. If after the first six (6) months of TMA coverage income remains over 138% but below 185% FPL, coverage can extend an additional six (6) months as long as POWER Account contributions are paid. The State will identify all members eligible for HIP Plus benefits that meet the eligibility criteria of this Section 3.1.1.

3.2 HIP Basic

HIP members with income at or below one hundred percent (100%) FPL who do not make either their fast track prepayment, initial or subsequent POWER Account contributions as required by Section 4.1.1 will not be eligible for HIP Plus, and will be transferred to a more limited benefit package, which requires copayments for services as set forth in Section 4.1.2 (HIP Basic).

3.2.1 HIP Basic Potential Plus

If a member is determined to now be eligible for HIP Plus, they will be assigned to the Basic benefit package called HIP Basic Potential Plus. This could apply to a member who had other IHCP coverage and transitioned into the HIP program, a member who was previously covered under Presumptive eligibility, or a member who has earned rollover as a result of the POWER Account reconciliation process. The member will remain in Potential Plus status until the first POWER Account contribution or the fast track payment is made. The member has sixty (60) days to make a payment and move to HIP Plus.

Once the Contractor receives the POWER Account contribution, they will notify the state via the payday file submitted to *Core*MMIS. Once the member's payment is applied they will be moved to HIP Plus and the Contractor will be notified via the 834 of the benefit plan change.

3.2.2 Low Income Adults

Individuals referenced under 3.1.1 may default to HIP Basic benefits in the first six months of TMA coverage for failure to pay. Individuals referenced in 3.1.1 are not eligible for TMA after the second six months of coverage.

3.3 HIP State Plan

The Contractor shall provide HIP State Plan benefits to HIP members meeting any of the eligibility criteria listed in this Section 3.3. Unless otherwise exempt from cost-sharing as set forth in Section 4.1.4, all members receiving HIP State Plan benefits will either pay monthly POWER Account contributions consistent with the HIP Plus plan as set forth in Section 4.1.1 (HIP State Plan Plus) or, if at or below 100% FPL or other eligible for HIP State Plan Basic pursuant to Section 4.7.1.1, pay copayments for services as required under the HIP Basic plan as set forth in Section 4.1.2 (HIP State Plan Basic).

3.3.1 Low Income Adults

Section 1931 eligible parents and caretaker relatives eligible under 42 CFR 435.110, shall receive HIP State Plan benefits.

3.3.2 Medically Frail

The Contractor shall provide HIP State Plan services to members who meet the definition of medically frail. Consistent with 42 CFR §440.315(f), an individual will

be considered medically frail if he or she has one or more of the following:

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

3.3.2.1 State Identification of Medically Frail

Eligible members with a disability determination based on Social Security Administration criteria are automatically confirmed medically frail by the State, and the Contractor will not be responsible for verifying the medically frail designation.

Eligible members who have been confirmed HIV positive and identified to the State by the Indiana Department of Health will be automatically confirmed medically frail by the State, the Contractor will not be responsible for verifying the medically frail designation.

3.3.2.2 Medically Frail Determination

The Contractor shall utilize the Milliman Medical Underwriting Guidelines ("Milliman Guidelines") to determine a medically frail designation, a HIP member may be designated as medically frail at any time during the member's twelve (12) month benefit period, provided such designation is supported by the Milliman Guidelines.

In accordance with Section 7.2.3, the Contractor shall conduct an initial health needs screening of all new members within ninety (90) calendar days of a new member's enrollment in the Contractor's plan. The initial health needs screening shall be followed by a detailed comprehensive health assessment conducted by a health care professional in order to gather applicable information to compare against the Medical Underwriting Guidelines. The comprehensive health assessment may include a full review of important relevant clinical information such as the provider's assessment of conditions and the severity of illness, treatment history and outcomes, other diseases, illnesses, and health conditions as well a review of the member's available claims, including pharmacy claims.

The Contractors shall apply the Milliman Guidelines to either the information obtained in the initial health needs screening and comprehensive health assessment, or the member's claims history to generate debit points for the member. The member would qualify as medically frail based on the member's qualifying conditions and related risk scores as follows:

- 150 debit points for indicated medical conditions;

- 150 debit points for combined indicated medical, behavioral health and substance abuse conditions;
- 75 debit points for indicated behavioral health conditions;
- 75 debit points for indicated substance abuse conditions; or
- Needs assistances with one of the activities of daily living.

Either the member, provider or the Contractor may initiate a medically frail assessment during the member's benefit period. The Contractor shall establish a process to allow members to self-identify as medically frail to the Contractor. If requested by the member, the Contractor shall conduct a medically frail assessment in accordance with this Section 3.3.2.2 within thirty (30) days of the member's self-identification.

If the results of applying the Milliman Guidelines supports a medically frail designation, the Contractor shall document and support the decision. Documentation may include, but is not limited to (i) output files from the Milliman Renewal MUGs tool indicating the number of debit points the member accumulated; (ii) completed comprehensive health assessment tool; (iii) documentation of attempts to make contact with their member and/or physician(s); (iv) recorded responses and supporting information indicating member impairment in Activities of Daily Living (ADLs); (v) supplemental information gathered by the Contractor in order to make a complete decision (such as lab results, physician notes or lifestyle factors).

The Contractor shall notify the State's fiscal agent in the manner and timeframe determined by the State and established in the HIP MCE Policies and Procedures Manual when a HIP member or HIP lockout applicant (as described in Section 4.7.1.2) is determined medically frail by the Contractor.

Upon receipt of the medically frail confirmation, the State will transfer the member to HIP State Plan benefits effective the first day of the month following receipt of the medically frail confirmation. If, following a medical frail assessment, the results of the claims history and/or pharmacy data review do not support a medically frail designation, the Contractor shall inform the member that they will remain in their current HIP benefit plan.

The Contractor is responsible for notifying the member of the ultimate medically frail designation decision, any changes to the member's benefits, as well as the member's right to appeal in accordance with Section 7.9.

3.3.2.3 Medically Frail Annual Review

The Contractor shall maintain documentation that every medically frail member meets specific medically frail criteria, as set forth by OMPP, for receipt of HIP State Plan benefits. The Contractor shall confirm a member's status as medically frail at least annually, except for those members mentioned in 3.3.2.1, from the member's most recent medically frail determination in accordance with a process as determined by OMPP. At minimum, the Contractor shall affirm the medically frail designation by conducting an annual review of the member's claim history and/ or pharmacy data against the Milliman Guidelines.

Following the completion of the annual medically frail confirmation, the Contractor shall notify the State's fiscal agent of the results no later than fifteen (15) calendar days prior to the one year anniversary of the Contractor's previous medically frail determination or confirmation, as applicable. If a member is determined no longer to be medically frail, the member will be transferred to either (i) HIP Plus if they are currently making the required POWER account contributions, or are otherwise over 100% FPL, or (ii) HIP Basic if they are currently paying copayments at the time of service and under 100% FPL.

3.3.2.4 State Audit

The State will conduct regular audits of the Contractor's Medically Frail assessment and confirmation process pursuant to Section 3.3.2.2, to determine appropriate identification and placement of medically frail members. The State anticipates that less than ten percent (10%) of the Contractor's total newly eligible adult HIP population will be designated as medically frail. The Contractor shall consistently apply the Milliman Guidelines to every medically frail determination and review.

3.4 Pregnancy Coverage under HIP

Effective February 1, 2018, HIP members who become pregnant will receive maternity benefits through the HIP Maternity (MAMA) benefit plan. IHCP approved applicants with income at or below 138% FPL who are pregnant will be enrolled in the HIP Maternity program. IHCP approved applicants above 138% FPL who are pregnant will be served by the MAGP program. Members will not change programs during pregnancy or at their eligibility redetermination. A new aid category (MAMA), branded as "HIP Maternity", will be created for those members at or below 138% FPL. The member will be moved into the MAMA aid category on the first day of the month following the month in which the State becomes aware a member is pregnant. The Contractor will not move the member into MAMA for past months, only future months.

The Contractor shall develop policies and procedures for quickly identifying pregnant HIP members. The Contractor shall notify the State's fiscal agent within one (1) business day of confirming a member's pregnancy. The notice shall include the pregnancy start date as well as the expected delivery date. Date of confirmation for purposes of this Section 3.4 shall mean the date the Contractor receives notification of member pregnancy from the provider, whether through the official NOP form described in Section 9.2.3 or otherwise. In the event the Contractor discovers member pregnancy prior to provider confirmation, such as through claims data, the Contractor shall confirm member pregnancy with the provider within three (3) business days of discovery, provided the member has engaged with a provider.

Pregnant members shall not be subject to any cost sharing. Once pregnancy has been confirmed, and following notification from the State, the Contractor shall suspend the member's POWER Account and all member cost-sharing, including POWER Account contributions and/or copayments, as applicable, effective the first day of the month following the notification from the State. Pregnancy notifications received by the State less than six (6) business days prior to the end of the month will be processed to be effective the first day of the subsequent month. Notwithstanding the foregoing, at no time shall claims with a diagnosis of pregnancy be subject to member cost-sharing. The Contractor is responsible for reporting that members who become pregnant are exempt from cost-sharing via the supplemental file when they report the member's pregnancy. The Contractor shall have policies and procedures in place for quickly identifying pregnant

members and suspending all cost-sharing.

The Contractor is responsible for informing the member of their HIP Maternity coverage. This information shall, at minimum, be included in the Contractor's Member Handbook, as described in Section 7.4.1. The Contractor shall also work closely with its providers to complete the Notification of Pregnancy risk assessment on all pregnant members, as detailed in Section 9.2.3.

The Contractor shall notify the State's fiscal agent within one (1) business day of discovering the date of the end of the pregnancy. The submission of the supplemental file indicating that a member delivery has occurred generates a maternity delivery capitation payment for HIP members. Refer to the HIP MCE Policies and Procedures Manual for specific information.

The Contractor shall inform members, in writing, that in order to receive HIP coverage following the end of pregnancy, the member shall promptly report the end of pregnancy. The notice shall incentivize members to report the end of pregnancy to the Contractor as soon as possible.

HIP Maternity benefits will end on the first of the month after the sixty (60) day post-partum period. The Contractor will provide pregnancy, post-partum, and HIP benefits aligned with the dates and benefits specified on the 834. The Contractor shall communicate regularly with the member during the post-partum period. Additional guidelines regarding the Contractor's responsibility to assist pregnant members obtain and maintain coverage are located in the HIP MCE Policies and Procedures Manual.

As members transition from MAMA or MAGP benefit categories following the sixty (60) day post-partum period, their POWER Account and cost sharing will begin and they will be assigned to the HIP Basic Potential Plus category. They will have sixty (60) days to make the first POWER Account contribution in order to move to the HIP Plus benefit category. The Contractor is responsible for informing the member of the change from the MAMA or MAGP benefit category to the HIP Basic Potential Plus category and the method for the member to obtain HIP Plus benefits.

When a member enrolls in HIP Maternity in her third trimester of pregnancy, the Contractor shall honor the member's request to continue to receive maternity care from her current physician and reimburse for covered services provided to the member by her current physician, regardless of whether the physician is in the Contractor's network.

Until the implementation of MAMA HIP Maternity, expected February 1, 2018, HIP members that become pregnant will continue to have the option to remain in HIP until their redetermination or to transition to MAGP. Any HIP member that hits their redetermination prior to the implementation of the MAMA category will transition to MAGP.

Policies, procedures and POWER Account technical requirements related to pregnancy are documented in the HIP MCE Policies and Procedures Manual. The Contractor shall be required to comply with the requirements set forth in these documents as of the effective date of the Contract.

3.5 Presumptive Eligibility- HIP

Individuals determined presumptively eligible for HIP before 1/1/2019 in accordance with 42 CFR §435.1110 will be enrolled with an MCE for a presumptively eligible period, which begins on the day a qualified hospital, qualified provider or other authorized entity makes a determination that the individual is presumptively eligible. Individuals determined

presumptively eligible on 1/1/2019 and after, will be in the Fee for Service program

During the member's presumptively eligible period, the Contractor shall provide health benefits equivalent to the HIP Basic plan benefits, as described in Exhibit 6 of this Contract. The member will not be provided a POWER Account during the presumptively eligible period; however, the member will be subject to copayments for services as set forth in Section 4.1.2. The Contractor shall reduce reimbursement to providers for services rendered to a presumptively eligible member by the amount of the individual's required copayment.

The presumptive eligibility period will continue in accordance with the requirements in the HIP MCE Policies and Procedures Manual but should not be longer than (1) the last day of the month following the start of the presumptive eligibility period for individuals who do not file an application; (2) the day of the IHCP application denial for individuals that file an application but are not found eligible for coverage; or (3) for individuals that file an IHCP application and are found eligible for HIP the first day of the month following the determination of eligibility.

Individuals determined presumptively eligible for HIP (Adult PE) will not have a break in coverage if they are found eligible for Medicaid through the IHCP application process. Once found eligible, presumptively eligible members will be enrolled in the applicable HIP Plan. This enrollment will coincide with the end of the presumptive eligibility period and begin the 1st day of the month following the end of the presumptive eligibility period. Presumptively eligible members who made a fast track payment during the standard fast track process will be enrolled in HIP Plus. Presumptively eligible members who have not made a fast track payment will be enrolled in HIP Basic and will have the opportunity to pay to move to HIP Plus as detailed below.

Members who are determined eligible under the Adult PE eligibility category during their presumptively eligible period are moved to the HIP Basic category when their full IHCP application is approved:

- Members transitioned from Adult PE who make a POWER Account payment within sixty (60) days from the date they filed their IHCP application, or their anchor date, will be enrolled in HIP Plus effective the first day of the month after payment is received.

- Members transitioned from Adult PE who do not make a POWER Account payment in the 60-day time frame who have household income equal to or less than 100% of the federal poverty level (FPL), will stay enrolled in HIP Basic. These members are not eligible to buy in to HIP Plus until eligibility redetermination or the application of rollover.

- Members transitioned from Adult PE who do not make a POWER Account payment in the 60-day time frame and who have household incomes greater than 100% FPL will be terminated from HIP effective at the end of the month, following required adverse action timelines.

The Contractor shall comply with the policies and procedures set forth in HIP MCE Policies and Procedures Manual. The Contractor shall be required to comply with the requirements set forth in the document as of the effective date of the Contract.

3.6 Gateway to Work (GTW) Program

The Contractor shall be responsible for administering the HIP GTW program according

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to the GTW eligibility and operational requirements outlined in the MCE Policy and Procedure manual. The Contractor shall participate in GTW readiness reviews, conducted by OMPP, which may include documentation provided by the Contractor and on-site walkthroughs.

The State will assign a GTW Referral Status for all fully eligible HIP members and provide the Referral Status to the Contractor. For all members who are referred to participate in the GTW program, the Contractor shall monitor each member's compliance with the required GTW community engagement hours using the data provided by the member in the GTW member portal.

The Contractor shall complete all outbound GTW member communications requirements as applicable to each member participating in GTW according to the MCE Policy and Procedure manual. The Contractor shall assist members who contact the Contractor regarding help with GTW requirements and shall conduct assessments and develop Assistance Plans according to the requirements set forth in the MCE Policy and Procedures manual. If during the assessment process, the Contractor identifies an exemption to the member's participation in GTW or a member reports an exemption, the Contractor shall appropriately record or refer the exemption depending upon the type of exemption identified. The Contractor shall attempt to develop an Assistance Plan for a member if the member meets the criteria set forth in the MCE Policy and Procedure manual, including for failure to comply with GTW reporting requirements, or if the member requests an Assistance Plan. The Contractor shall conduct outreach to GTW members with an Assistance Plan per the requirements set forth in the MCE Policy and Procedure manual. If the member is non-compliant with GTW requirements when the Assistance Plan expires, the Contractor shall assess if a new Assistance Plan is appropriate.

In accordance with the MCE Policy and Procedure manual, each calendar year the Contractor shall review Gateway to Work compliance for each member required to participate in the program based upon the referral status provided by the State. Non-compliant members will have the opportunity to complete pre-suspension activities, and the Contractor shall conduct all pre-suspension activity communication requirements. The State shall make all final eligibility decisions related to a member's compliance with GTW requirements.

The Contractor shall complete their assigned number of GTW verifications of member qualifying activities at the frequency required by the State. Verifications shall be completed on a sample of member accounts with a GTW reporting status according to the methodology and requirements set forth in the MCE Policy and Procedure manual. The Contractor shall report the results of each monthly verification to the State, in the format approved by the State, at which time the State may validate the results.

The Contractor shall address member grievances related to GTW according to the MCE Policy and Procedure Manual and per the requirements of Section 7.9. The Contractor shall participate in the appeal process, as required by the State, for any GTW appeals as set forth in Section 7.9.

4.0 Billing and Collections

Except for members exempt from cost sharing pursuant to Section 4.1.4, all HIP members are responsible for making financial contributions to their health care coverage, either through regular POWER Account contributions or HIP Basic copayments for services. The Contractor shall be responsible for billing, collecting and applying applicable POWER Account contributions for members receiving HIP Plus or HIP State Plan Plus benefits.

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Collection services shall include:

- Creating and maintaining HIPAA compliant POWER Account contribution billing services;
- Generating and mailing invoices, although members may opt-in to receiving electronic invoices;
- Receiving and posting payments;
- Monitoring and tracking missed payments;
- Processing returned checks;
- Stopping or placing collections on hold as directed by the State;
- Generating past due notices and other notifications;
- Generating other informational materials as requested by the State;
- Providing documentation of account activities and other financial reports;
- Processing and mailing fast track prepayment and/or POWER Account contribution refunds;
- Transferring collected funds as requested by the State;
- Documentation and reconciliation of funds received and transferred;
- Establishing and handling a lockbox for HIP payments;
- Providing services online that support and interface with the State's current website;
- Ensuring the integrity and accuracy of data exchanged with or provided to the State, and that the data is compatible with other software, hardware or systems used by the State;
- Ensuring compliance with current bankruptcy rules, the Cash Management Improvement Act of 1990 guidelines (Public Law 101-453), confidential information and electronic transaction processing procedures;
- Adhering to established health care industry standards, in addition to any Medicaid rules, regulations and or mandates, as well as amendments thereto;
- Date stamping mail received; and
- Forwarding all change of address notifications and mail returned as undeliverable as specified by the State.

Additionally, while the Contractor is not required to promote cash payment by mail as a payment option, the Contractor shall be equipped to accept cash payments, including cash payment by mail, if submitted by the member. Further, the State encourages arrangements with local entities to facilitate the collection of contributions, including no-cost options for collecting cash contributions. In addition, the State will assist the Contractor by identifying vendor(s) that can accept cash contributions. The Contractor agrees to use commercially

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reasonable efforts to work with such vendor(s) to accept cash contributions at no cost to the member. The Contractor shall ensure that any cash contributions collected by third party vendors in accordance with this Section 4 are credited toward the member's POWER Account within two (2) business days. More information about preferred vendor(s) and cash collection methods may be found in the HIP MCE Policies and Procedures Manual.

The State will determine the member's required POWER Account contribution amounts during the application process and will notify the Contractor of these amounts. The required POWER Account contribution will be provided to the Contractor in both an annual benefit period amount and a monthly billing amount. POWER Account contributions will be recalculated by the State during eligibility redetermination, and as otherwise required throughout the benefit period based on member reported changes, in accordance with Section 4.4 below.

4.1 Individual Cost-Sharing Obligations

As detailed in Section 6.16, the Contractor shall ensure that member cost sharing as set forth in this Section 4.1 does not exceed 5% of family income as calculated on a quarterly basis, except that all HIP Plus or HIP State Plan Plus members whose household income is at or below five percent (5%) of the FPL will be required to contribute, at a minimum, monthly one dollar ($1.00) POWER account contributions. The Contractor will work with the State to consider all contributions made by the household in the calculation and monitoring of the 5% contribution limit. The Contractor will have the ability to identify members who have reached the maximum contribution and to cease that member's cost sharing obligations in accordance with the HIP MCE Policies and Procedure Manual. While the Contractor has the primary responsibility for tracking member's cost sharing, the Contractor shall also have a process in place that allows a member to self-report on their expenditures and have a process in place to end cost sharing based on member provided documentation.

In addition to the cost-sharing set forth below, all HIP members (with the exception of members exempt from cost-sharing as described in Section 4.1.4) will be required to make an $8.00 copayment for non-emergent use of hospital emergency departments, as further described in Section 6.6.2.

4.1.1 HIP Plus Member Cost-Sharing

In order to participate in HIP Plus or HIP State Plan Plus, members are required to help fund their $2,500 deductible by contributing to their POWER Account on a monthly basis. Required contributions will be calculated based on a tiered contribution structure. The tier contribution structure assigns a specific POWER Account contribution amount, roughly equivalent to 2% of income, based on the member's FPL. For married couples participating in HIP Plus, the State will divide the monthly contribution between the two HIP eligible married adults, and each member will be responsible for half of the calculated amount on a monthly basis. Individuals who have indicated they are tobacco users will be required to pay an increased contribution amount beginning in the second calendar year benefit period as part of the tiered structure. In no event will a member's base monthly POWER account contribution be less than one dollar ($1.00).

Base HIP Plus member required contribution tiers based on 2% of income range from $1 to $20 per month. These amounts may be split between spouses, increased for tobacco surcharges, or reduced due to member rollover.

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Table 4.1.1: HIP Plus Contribution Tiers

FPL	Monthly PAC Single Individual	Monthly PAC Spouses	PAC with Tobacco Surcharge	Spouse PAC when one has Tobacco Surcharge	Spouse PAC when both have Tobacco Surcharge (each)
<22%	$1.00	$1.00	$1.50	$1.00 & $1.50	$1.50
23-50%	$5.00	$2.50	$7.50	$2.50 & $3.75	$3.75
51-75%	$10.00	$5.00	$15.00	$5.00 & $7.50	$7.50
76-100%	$15.00	$7.50	$22.50	$7.50 & $11.25	$11.25
101-138%	$20.00	$10.00	$30.00	$10.00 & $15.00	$15.00

The State will determine the member's required monthly POWER Account contribution and will notify the Contractor of this amount. The Contractor will be responsible for applying any tobacco surcharge or rollover credits or discounts to the POWER Account contribution amount determined by the state. In calendar year 2018 the Contractor must track members' tobacco use indicator. For calendar year 2019 the Contractor must begin applying the surcharge to the POWER Account invoice. The POWER Account contribution will change only when a member has a FPL change that moves the member to a different tier. Members may prepay their POWER account contribution amounts and the Contractor is responsible for refunding any member overpayments.

4.1.2 HIP Basic Member Cost-Sharing

Members enrolled in HIP Basic or HIP State Plan Basic are not required to make monthly contributions to their POWER Account, but are required to pay the following copayments at the time services are rendered:

- No copayment is required for preventative care, maternity services or family planning services.
- Four dollar ($4.00) copayment is required for outpatient services.
- Seventy-five dollar ($75.00) copayment is required for inpatient services.
- Four dollar ($4.00) copayment is required for preferred drugs.
- Eight dollar ($8.00) copayment is required for non-preferred drugs.

The Contractor shall also establish education and policies and procedures for its contracted providers to collect copayments for HIP Basic members at the time of service.

4.1.3 HIP State Plan Member Cost-Sharing

Other than individuals exempt from cost-sharing as set forth in Section 4.1.4, all members receiving HIP State Plan benefits shall either pay POWER Account contributions in the amounts set forth in Section 4.1.1 if the member is enrolled in HIP State Plan Plus, or copayments for services as set forth in Section 4.1.2 if the member is enrolled in HIP State Plan Basic. Members that qualify as medically

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frail under Section 3.3.2 may be subject to both HIP Plus contributions and copayments when their income is over 100% of the FPL and they have not made their POWER account contributions.

4.1.4 Exempt Populations

Pursuant to federal law, the Contractor may not collect POWER Account contributions or impose any other cost-sharing, including co-payments for non-urgent use of hospital emergency departments, on members who are pregnant, members who have reached their 5% cost sharing requirement, or members identified as an American Indian/ Alaska Native (AI/AN) pursuant to 42 CFR 136.12. The State will identify all AI/AN members through the eligibility determination process.

4.1.5 Tobacco Surcharge

HIP tobacco users who do not cease tobacco use will be charged a tobacco surcharge.

A tobacco user is defined as a person who uses tobacco on average of four (4) or more times per week with a look back period of six (6) months from the date of attestation. The definition of tobacco includes: chewing tobacco, cigarettes, cigars, pipes, hookah, and snuff. The determination to charge a surcharge is only accessed at the beginning of the benefit period and will apply for the entire benefit period. The tobacco surcharge is calculated as 50% of the member's POWER account contribution. The Contractor is responsible for calculating, tracking, and billing the tobacco surcharge on the member's monthly invoices. The Contractor is responsible for applying the tobacco surcharge on a calendar year benefit period for members who have indicated they were a tobacco user in the prior benefit period and have had at least 12 months to access quit resources but have not indicated they have stopped smoking. When assessing the application of the surcharge, the Contractor is responsible for identifying any member who has a self-attested tobacco indicator of Yes with a date of 12 months plus 1 day from the month being invoiced. Operational requirements are outlined in the MCE policy and procedure manual. The surcharge is applicable for the entire calendar year, even if the member's tobacco use status changes to No during the calendar year. POWER Account amounts will be determined per normal procedure by the eligibility system. The Contractor will invoice the tobacco surcharge based on the tobacco indicator, regardless of the Contractor's information on tobacco use collected via claims data.

*Core*MMIS will store the tobacco use indicator and date and will pass the information to the Contractor. The Contractor is responsible for allowing the individual to report tobacco use or cessation of tobacco use at any time. Member self-reporting of tobacco use requires the updating of indicator by the Contractor. The tobacco use indicator may be updated by the Contractor via a supplemental file at any time. The indicator is only updated when an individual self-attests to tobacco use or tobacco non-use. The indicator cannot be updated via utilization or risk assessment data. A member can have their designation changed from yes to no for smoking during the year; however, the change in the indicator does not impact the member's current tobacco surcharge. Once updated via the supplemental file, the indicator is passed back to the Contractor on the 834.

The Contractor is responsible for allowing for member grievances and appeals relating to the tobacco surcharge as detailed in the MCE Policy and Procedures manual. A formal grievance or appeal decision may change the member's tobacco

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surcharge during the benefit period.

4.2 State POWER Account Contributions

The State will fund any gap between a member's required contribution and the $2,500 deductible. For members on HIP Basic or HIP State Plan Basic who make copayments instead of POWER Account contributions, the State will fund the entire POWER Account.

For purposes of illustration, if a HIP Plus member's annual income is 100% FPL and their contribution is $15 per month, after 12 months of enrollment the member will be responsible for $180 of the POWER Account. When the POWER account is reconciled the state will pay $2,320 to the Contractor and any State POWER account balance not spent on covered member services will be refunded.

The State will make an initial contribution of $1,300 to the POWER Account promptly after receiving notice from the Contractor that the member's first POWER Account contribution has been processed. State contributions shall be credited to a member's POWER Account immediately upon receipt by the Contractor from the State. At the conclusion of the member's calendar year benefit period, the Contractor and the State shall reconcile the POWER Account balance in accordance with Section 5.8.4, which shall include determining any amounts owed by the State to cover the difference between the sum of the members required monthly contributions and the initial $1,300 contribution. During reconciliation, the maximum additional State liability towards the POWER Account will be $1,200 based on member claims and contributions.

4.3 Third Party POWER Account Contributions

Third parties, including the member's employer, are permitted to contribute towards an individual's POWER account contribution up to one hundred percent (100%) of the member's required POWER Account contribution amount. Such third-party contributions shall be credited to a member's POWER Account upon receipt. Any third-party contribution shall be used to offset the member's required contribution only, and not the State's contribution.

The Contractor shall keep record of all contributions made by third parties on behalf of members and make available to the State as outlined in the HIP MCE Reporting Manual.

4.4 Recalculations

A member shall report all changes to the State that may affect eligibility and POWER Account contributions, including changes in income or family size, such as a death, divorce, birth or a family member moving out of the household. The State will notify the Contractor if a member's POWER Account contribution changes as a result of the reported change. The Contractor shall begin billing the new POWER Account contribution in the billing cycle immediately following the change.

4.5 Billing and Collections

The Contractor shall develop and mail invoices for HIP members that include the following information:

- The name of the Contractor;
- First name, last name and address of payor;

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- First names of members;
- Current monthly POWER Account contribution owed;
- Tobacco surcharge owed;
- POWER Account contribution past due;
- Overpayment shown as credit;
- Payor MID of the person responsible for payment;
- Consequences of not paying the POWER Account contribution;
- Notice to send payment in all accepted forms, such as check, money order, on-line payment, unlimited electronic check or debit card via telephone, payroll deduction, automatic draft withdrawal from a designated account, cash payments or automated clearinghouse (ACH), including instructions on how to perform the transaction;
- How to notify the Contractor of an address change;
- How to report any change in household or household income;
- How to notify the Contractor when individuals or families have billing questions or concerns;
- How to contact the enrollment broker if the individual desires to change MCEs for just cause;
- Legal statement regarding bankruptcy, if applicable; and
- Any additional information as directed by FSSA.

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

The Contractor shall translate invoices into Spanish, as well as any other languages that are spoken by at least three percent (3%) of the general population in the Contractor's service area as determined by annual report from translation line requests or are requested by OMPP. Currently, the State notifies the Contractor of Spanish-speaking members only.

At a minimum, the invoice mailing shall include an invoice with a detachable payment coupon and a return envelope. As of June 1, 2020 the return envelope shall include pre-paid postage. Occasional one-page inserts may be required by OMPP to explain programmatic or billing changes. The Contractor shall provide members the option to sign-up and receive invoices via e-mail.

The Contractor shall bill for, and collect, POWER Account contributions and tobacco surcharge payments on a monthly basis. Partial monthly payments may be accepted by the Contractor; however, the member shall pay the monthly payment in full within sixty (60) days from the first day of the coverage month for which the POWER account contribution is owed or be subject to the non-payment penalties described in Section 4.7.

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The Contractor shall actively encourage members to make their POWER Account contributions utilizing member education, outreach and reminders. Member education and outreach should be included in new member materials and coordinated with any contact the Contractor makes with new members for health screenings, risk assessments and PMP selections.

The Contractor shall notify members when the member fails to make a POWER Account contribution and tobacco surcharge payment by the due date. The Contractor shall provide at least two (2) written notices of the delinquent payment as a payment reminder, the first of which shall be sent on or before the seventh (7th) calendar day of non-payment. The reminders shall include the following information, at a minimum:

- The date by which the contribution shall be paid to prevent the non-payment penalties described in Section 4.7.
- An explanation of the nonpayment penalty policies, including the exceptions as described in Section 4.7.1. The reminder shall also include information on how the member may request a medically frail screening in accordance with Section 3.3.2.2.
- For members over 100% FPL facing termination and lock-out for non-payment, an explanation that any final notice of termination from the program will come directly from the State and will include information about the member's appeal rights.
- For members over 100% FPL not subject to an exception listed in Section 4.7.1, a reminder that if the member is terminated from HIP for non-payment, the member will be not be able to participate in HIP for a period of six (6) months and that the member's portion of their POWER Account balance will be subject to a twenty-five percent (25%) penalty.
- An explanation of the member's appeal rights.
- Information regarding how to report any change in household composition or household income.
- A member helpline phone number for the member to call if they have any questions.

4.5.1 Payment Methods

The Contractor shall provide at least the following options for making payment:

- Check;
- Money order;
- Automatic payroll deduction;
- Cash;
- On-line payment via web portal;
- Unlimited electronic check or debit card payment via telephone;

- Automatic draft withdrawal from a designated account;
- Automated Clearinghouse (ACH); and
- Electronic funds transfer.

The cash payment process shall be available through a statewide network of banks or other entities in the business to handle/accept payments. In the case of a member with multiple employers, the Contractor is only required to provide the payroll deduction option for one of the member's employers at any given time. As an example, if the member changes employers, the member shall be permitted to make payments via payroll deduction with the new employer; however, if a person has multiple jobs, it is only required that the Contractor be able to accept one payment via payroll deduction at a time. Innovation by the Contractor in assuring the collection of member payments is highly desired.

Because POWER Account contributions are used to fund HIP members' $2,500 deductible, HIP conditionally eligible and fully eligible members shall be permitted to pre-pay some or all of their POWER Account contribution for the coverage period upon request at any time, including with their initial payment. Although additional payments may fully offset future billing, this does not relieve the Contractor's responsibility to send monthly invoices reflecting the amount due and credits on the account.

4.5.2 Employer and other Third Party POWER Account Contributions

The Contractor shall develop a program to publicize to members and employers that an employer and other third parties may contribute to the member's POWER Account.

Appropriate outreach materials should be developed and the Contractor shall assure that its member services staff can address calls from members, employers, and other third parties on this topic. Communications about employer contributions should be on-going and continuous, and the Contractor should consider collecting member employment data at the time of the health needs screening or other member contacts to use in its outreach efforts. The outreach materials for employers shall identify the process the employer can use to contribute to employee POWER Accounts.

Employers shall be allowed to make POWER Account contribution payments on a monthly basis. If an employer fails to provide its share of a member's POWER Account contribution within sixty (60) calendar days of its due date, the member shall have an additional sixty (60) calendar days to pay the overdue amount before being terminated from HIP.

The Contractor shall also allow employers and other third parties to make lump sum POWER Account payments. The Contractor shall ensure that lump sum payments are credited against the member's required POWER Account contributions on a first month's basis. For example, for a member with a $10.00 per month contribution, if an employer or other third party makes a one-time $50.00 contribution, the Contractor shall immediately credit the member's account and apply the payment to cover the immediately following five months of required member contributions.

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4.6 Enrollment and Initial POWER Account Contributions

4.6.1 Standard Enrollment

The standard initial billing and enrollment process described in this Section 4.6.1 shall be in effect for all applicants. The Contractor shall be required to comply with the fast track initial billing and enrollment process described in Section 4.6.2 below for all fast track eligible applicants identified by the State.

Except for American Indian/ Alaska Native (AI/AN) members, HIP member eligibility shall not be final until the first day of the month in which either (i) the POWER Account contribution is paid, or (ii) non-payment is determined for individuals at or below 100% FPL who choose not to participate in HIP Plus. A member's initial POWER Account contribution is due within sixty (60) calendar days of the date the Contractor receives a member's conditionally eligible file from the State.

The Contractor shall receive conditional eligibility files of individuals that selected, or were auto-assigned to, the Contractor's plan from the State. Within three (3) business days of receiving the conditional eligibility file, the Contractor shall send a Welcome Letter and initial invoice to the individual for their first POWER Account contribution. The first invoice shall reflect the member's monthly POWER Account contribution as determined by the State.

The Welcome Letter shall include a notice explaining that the individual shall submit their initial payment within sixty (60) calendar days in order to receive HIP Plus benefits. The notice shall be tailored to individuals at or below 100% FPL and those above 100% FPL. The Welcome Letter to individuals above 100% FPL shall explain that if the initial payment is not received within sixty (60) calendar days, the member's coverage will not commence and they will have to reapply for HIP. The Welcome Letter to individuals at or below 100% FPL shall explain that if the initial payment is not received within sixty (60) calendar days, their coverage under HIP Basic will begin on the first day of the month in which the sixty (60) day period ends. The Welcome Letter shall also have a notice prominently displayed on the first page stating in substance that the individual has the right to select another MCE before the first payment is made. Such notice shall include information for howthe individual may contact the enrollment broker to change MCEs. As with all member communications, the Welcome Letter shall be reviewed and approved by the State prior to use in accordance with Section 7.1.

The Contractor shall provide at least two reminders to individuals who have not made their first monthly POWER Account contribution.

Except for AI/AN members, an individual's enrollment in the Contractor's plan begins the first day of the month in which the first POWER Account contribution is processed, or after the nonpayment determination has been made for individuals eligible for HIP Basic or HIP State Plan Basic. The Contractor shall process all payments and notify the State of the payment within fifteen (15) calendar days of receiving the payment. The fifteen (15) calendar day period allows time to assure that payments made by check have cleared.

Members identified as an AI/AN pursuant to 42 CFR 136.12 are exempt from all cost-sharing, as set forth in Section 4.1.4, and therefore such member's enrollment in the Contractor's HIP Plus plan begins the first day of the month in which the member applied to the plan.

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4.6.2 Fast Track Enrollment

Except for AI/AN members, HIP eligibility shall not be final until either (i) the first day of the month in which the member pays an initial contribution to their POWER Account, or (ii) until the first day of the month in which the initial POWER Account fast track prepayment period expires for individuals at or below 100% FPL who choose not to participate in HIP Plus. For purposes of clarification, a member may enroll in HIP Plus by choosing to pay an initial ten dollar ($10.00) fast track POWER Account prepayment or the member's first month's POWER Account contribution in an amount determined by the State.

Fast track eligible applicants will be provided the opportunity to pay a ten dollar ($10.00) initial fast track POWER Account prepayment that expedites enrollment into the HIP Plus plan once an individual has been determined eligible by the State. The applicant may pay the fast track prepayment either immediately at the time of application or following receipt of a fast track invoice from the applicant's MCE.

For applicants that select an MCE and elect to pay via credit card at the time of application, the State will connect the applicant directly to the selected MCE's third party payment partner to collect and process each applicant's credit card payment. The Contractor shall store the application ID number, payment amount, and payment date at least until the date the Contractor is notified by the State of the applicant's final eligibility determination. The Contractor shall receive pending eligibility files of individuals that selected, or were auto-assigned to, their plan from the State and meet fast track eligibility criteria. The Contractor shall review all pending eligibility files and identify applicants who have provided payment information to the Contractor via the Indiana Health Coverage Program application. If the Contractor successfully verifies the payment, the Contractor shall send the State notice of payment within one (1) business day of receiving the pending eligibility file.

Within two (2) business day of receiving the pending eligibility file of either (i) an applicant who did not pay the fast track payment via credit card on the Indiana Health Coverage Application or (ii) whose credit card information was unable to be successfully verified and/or processed, the Contractor shall send an initial invoice to the individual for a ten dollar ($10.00) POWER Account fast track prepayment. The invoice shall include a notice explaining that the individual has not yet been determined eligible for HIP benefits, but the initial fast track prepayment shall be paid within sixty (60) calendar days in order for the potential member to be eligible to receive HIP Plus benefits. The notice shall encourage prompt payment of the fast track prepayment which could advance the potential member's benefit start date. Further, the initial invoice shall also include a prominent notice stating in substance that the potential member has the right to select another MCE at any time before the first payment is made. Such notice shall include information for how the potential member may contact the enrollment broker to change MCEs.

In addition, the notice shall clearly indicate that the fast track prepayment is an optional payment that either (i) will be fully refunded to the individual in the event the pending applicant is determined by the State not to be eligible for HIP, or (ii) will be applied towards the member's future required POWER Account contribution(s) in the event the potential member is determined eligible for HIP. The notice shall explain that if the member is determined eligible for HIP, their monthly POWER account contributions may be greater than the initial fast track prepayment, in which case, the member may owe more in the second month in order to continue to receive HIP Plus benefits. As with all member communications, the fast track

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enrollment notice shall be reviewed and approved by the State prior to use in accordance with Section 7.1.

A member's fast track prepayment or initial POWER Account contribution is due within sixty (60) calendar days of the date the Contractor receives the member's pending eligibility file from the State. The Contractor shall provide at least two (2) reminders during the sixty (60) day payment period to individuals who have not made their initial fast track prepayment or first monthly POWER Account contribution. The Contractor shall process all payments and notify the State of the payment within fifteen (15) calendar days of receiving the payment. The fifteen (15) calendar day period allows time to assure that payments made by check have cleared. Notwithstanding the foregoing, the Contractor may elect to hold fast track prepayments received from applicants not yet determined eligible by the State until such time the applicant is determined eligible. If the Contractor elects to hold such payments, the Contractor shall verify the payment and notify the State of receipt of a valid payment method within fifteen (15) calendar days of receipt. Once the applicant is determined eligible, the Contractor shall release the hold and process payment no later than fifteen (15) calendar days from the Contractor's receipt of the eligibility file. A member's enrollment in the Contractor's plan begins as follows:

i. If the member pays either the fast track prepayment or the initial POWER Account contribution within the original sixty (60) day fast track payment period, the effective date of coverage is the first day of the month in which the member made his or her initial payment. Potential members who pay the fast track prepayment prior to the State's eligibility determination will be directly opened into HIP Plus benefits upon the State's final eligibility determination.

ii. Members who have an open presumptive eligibility segment and make a fast track payment with their full IHCP application will open into HIP Plus the first day of the month following their fast track payment.

iii. If the potential member does not pay the fast track prepayment or their initial POWER Account contribution within the sixty (60) day payment period but is found otherwise eligible for HIP, the potential member will become conditionally eligible for HIP following the eligibility determination, and either:

   a. the effective date of coverage will be the first day of the month in which the sixty (60) day fast track prepayment period expired for individuals below 100% FPL or who are otherwise exempt from non-payment penalties in accordance with Section 4.7.1; or
   b. the individual will be determined ineligible and will have to reapply for HIP benefits if the individual is over 100% FPL and is not otherwise exempt from non-payment penalties in accordance with Section 4.7.1.

iv. Members identified as an AI/AN pursuant to 42 CFR 136.12 are exempt from all cost-sharing, as set forth in Section 4.1.4, and therefore, unless such member opts of out managed care via the process determined by the State, such member's enrollment in the Contractor's HIP Plus or HIP State Plan Plus plan, as applicable, begins the first day of the month in which the individual applied for the plan.

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As described in subsection (ii) above, a potential member who is determined eligible for HIP by the State before the initial fast track prepayment was received and prior to the expiration of the sixty (60) day fast track payment period, will be considered conditionally eligible. Within three (3) business days of receiving the conditionally eligible file, the Contractor shall send a Welcome Letter to the conditionally eligible member. The Welcome Letter shall be tailored to individuals at or below 100% FPL and those above 100% FPL.

a. The Welcome Letter to members above 100% FPL shall explain that if either the initial fast track prepayment or full POWER Account contribution is not received prior to the expiration of the sixty (60) day fast track payment period, the member's coverage will not commence and they will have to reapply for HIP.

b. The Welcome Letter to members at or below 100% FPL shall explain that if either the initial fast track prepayment or full POWER Account contribution is not received prior to the expiration of the sixty (60) day fast track payment period, the member's coverage under HIP Basic will begin on the first day of the month in which the payment period expires.

The Contractor's Welcome Letter to all conditionally eligible members who have not yet made a fast track prepayment shall include a notice that if the member's POWER Account contribution is greater than ten dollars ($10.00) the initial fast track prepayment is the minimum required to obtain HIP Plus benefits and start the program, however, the member will remain responsible for the full amount of the POWER Account contribution during the first month of coverage and such amount will be included on the subsequent month POWER Account invoice. The Welcome Letter shall also have a notice prominently displayed on the first page stating in substance that the individual has the right to select another MCE at any time before the first payment is made. Such notice shall include information for how the individual may contact the enrollment broker to change MCEs. As with all member communications, the Welcome Letter shall be reviewed and approved by the State prior to use in accordance with Section 7.1.

Due to the fact that the Contractor may collect the initial fast track prepayment before the member's individual POWER Account contribution has been determined by the State, the Contractor will be required to reconcile any overpayments or underpayments resulting from the fast track prepayment. Specifically, if the member's POWER Account contribution is less than the fast track prepayment, the Contractor shall credit the fast track prepayment against the member's required POWER Account contributions on a first month's basis. For example, for a member with a $1.00 per month contribution, the Contractor shall immediately credit the member's account and apply the payment to cover the first ten months of required member contributions. By contrast, if the member's POWER Account contribution is greater than the fast track prepayment, the Contractor shall credit the fast track prepayment to the member's first month's required POWER Account contribution and add the remaining balance to the member's subsequent POWER Account contribution. The member will have sixty (60) calendar days to pay the remaining balance.

For individuals who pay their fast track prepayment within the sixty (60) day payment period but who are determined ineligible for HIP, the Contractor shall return any such funds within ten (10) business days of the determination.

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HEALTHY INDIANA PLAN SCOPE OF WORK

4.7 Non-Payment of Monthly POWER Account Contribution

Other than the exceptions listed in Section 4.7.1, HIP members who do not make a required POWER Account contribution within sixty (60) calendar days of its due date or an initial fast track prepayment prior to the expiration of the sixty (60) calendar day fast track period will either be (i) terminated from the program and disenrolled from the Contractor's plan if the member has income greater than 100% FPL, or (ii) transferred to HIP Basic benefits if the member has income equal to or less than 100% FPL or are otherwise exempt from non-payment penalties, in accordance with Section 4.7.1. Notwithstanding the foregoing, upon non-payment, members receiving HIP State Plan benefits who either have income equal to or less than 100% FPL or are otherwise exempt from non-payment penalties as set forth in Section 4.7.1 will be required to make co-payments consistent with Section 4.1.2, but will not be subject to a change in benefits.

Payment via a dishonored check due to non-sufficient funds (NSF) will be considered non- payment, and members who have made such a payment will be terminated from the program or transferred to HIP Basic, as applicable, if they are unable to provide the full amount that is in delinquency within sixty (60) calendar days of its original due date. If a member's check is returned for non-sufficient funds, the Contractor may charge a reasonable fee for the returned check. The Contractor shall develop, print and mail notices to members if their payments are returned from the bank due to non-sufficient funds.

The Contractor shall notify the State, through *Core*MMIS, when a member does not pay their initial fast track prepayment by its due date, or their POWER Account contribution within sixty (60) calendar days of its due date. Upon the expiration of the payment due date, if no payment has been received, the Contractor shall send notification to the State electronically in accordance with the HIP MCE Policies and Procedure manual no later than three (3) business days from the expiration of the payment due date. The Contractor shall wait until either a termination record is received from the State to terminate a fully enrolled member from the plan, or until other notice is received from the State indicating a change in benefits to HIP Basic.

4.7.1 Non-Payment Penalty Exceptions

Members exempt from cost-sharing pursuant to Section 4.1.4 shall not be subject to any of the non-payment penalties set forth in Section 4.7. In addition, certain members will be exempt from program disenrollment due to non-payment as set forth in Section 4.7.1.1. In addition, Section 4.7.1.2 sets forth exceptions to the six month member lock-out after a member has been disenrolled from the program in accordance with Section 4.7. The Contractor is responsible for informing members of these non-payment penalty exceptions as detailed in Sections 4.7 and 7.4. Refer to the HIP MCE Policies and Procedures Manual for specific information related to the non-payment penalty exceptions.

4.7.1.1 Disenrollment Exceptions

The following members will not be subject to disenrollment due to non-payment:

Members confirmed medically frail in accordance with Section 3.3.2 will not be terminated from the program due to non-payment. In the event a medically frail member with income over 100% FPL does not make a payment within sixty (60) calendar days of its due date, the Contractor shall notify the State of nonpayment as detailed in Section 4.7. However,

the medically frail member will continue to receive HIP State Plan benefits, but will be required to make copayments consistent with Section 4.1.2. The Contractor shall continue to send monthly POWER Account invoices to such medically frail members above 100% FPL, and the member will continue to incur debt to the Contractor for unpaid POWER Account contributions. The Contractor shall ensure that the member's total expenses, including any paid debt, copayments, and POWER account contributions, do not exceed the five percent (5%) of income maximum during any quarter as set forth in Section 6.16. Members may regain access to HIP State Plan Plus without copayments during their 12-month eligibility redetermination in accordance with Section 5.6.

i. Parent/caretaker members receiving transitional medical assistance (TMA) as set forth in Section 3.3.1 shall either attain or remain in HIP Plus coverage for up to twelve (12) months during their TMA eligibility period as long as POWER Account contributions are made. If after the first six (6) months of TMA coverage income remains over 138% but below 185% FPL, coverage can extend an additional six (6) months as long as POWER Account contributions are paid.

4.7.1.2 Lock-Out Exemption

A member who has been terminated for non-payment in accordance with Section 4.7 may be reinstated to the program prior to the expiration of the six month lock out period, if evidence is provided, along with a new application, that the member either:

i. Was a victim of domestic violence at the time the member was terminated for non-payment;
ii. Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the sixty (60) calendar days prior to date of member termination for non-payment;
iii. Became medically frail;
iv. Moved out of state after a missed payment;
v. Obtained private insurance any time after a missed payment; or
vi. Had an unreported change in income that would have otherwise disqualified the individual from eligibility.

Individuals in a six month lock out who are identified upon a new application as potentially medically frail shall be screened by the Contractor in accordance with Section 3.3.2. If the State determines the individual is otherwise eligible for the plan but for the application of the lock out period, the individual will be considered conditionally eligible for HIP benefits pending the Contractor's medically frail determination. The Contractor shall notify the State's fiscal agent of the medically frail determination in the manner and timeframe determined by the State and established in the HIP MCE Policies and Procedures Manual.

5.0 Personal Wellness & Responsibility (POWER) Accounts

The Contractor shall establish and administer a POWER Account for each HIP member,

regardless of whether the member is required to contribute to the POWER Account. HIP members will use the funds in their POWER Account to meet their $2,500 deductible. Effective January 1, 2018 POWER Accounts are administered on a calendar year basis, and a member who leaves HIP and returns within the same calendar year will have their POWER account reactivated.

As explained in Section 4 above, HIP members, the State and, in some cases, employers and other third parties will contribute to the POWER Account. POWER Accounts are designed to provide incentives for members to stay healthy, be value- and cost-conscious and to utilize services in a cost-efficient manner as well as to seek price and quality transparency. HIP members shall be aware that prudent management of their health care expenditures can leave them with available POWER Account funds at the end of the calendar year benefit period—and that these funds can be used to lower next year's contribution for participation in HIP Plus.

The POWER Account requirements set forth in this section apply only to the Contractor's HIP members. The Contractor shall be required to comply with the requirements set forth in these documents as of the effective date of the Contract.

5.1 POWER Account Administration

POWER Accounts will be funded in an amount equal to $2,500. HIP Plus members, as well as the State, will contribute to their POWER Account. Employers are also encouraged to contribute to member POWER Accounts. By contract, HIP Basic members will manage a POWER Account fully funded by the State. HIP Maternity members will have a POWER Account, however, this account will be in suspended status and no claims may be applied to it for the duration of the member's HIP Maternity enrollment.

In families with two or more HIP-eligible adults, each member will have their own, individual POWER Account. Family members may participate in different HIP benefit plans and may choose to enroll in different MCEs.

5.2 Use of POWER Account Funds

Each member will be responsible for the use of funds in his or her POWER Account until the deductible is met. However, POWER Account funds can only be used by the member to pay for HIP covered services applicable to the member's HIP benefit plan. A summary list of the HIP covered services by benefit plan is provided in Exhibit 6 of this Contract. Any service not specifically listed as a covered benefit in the applicable HIP alternative benefit plan may not be applied against the POWER Account.

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

- Family planning services, if obtained from a IHCP provider;
- Emergency medical services;
- Other self-referral services outlined in Section 6.2, if obtained from a IHCP provider;
- Medically necessary covered services, if the Contractor's network is unable to provide the service within a 60-mile radius of the member's residence, as specified in 42 CFR 438.206(b)(4), which addresses out-of-network coverage of necessary services, and Section 6.14; and

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- Nurse practitioner services, if provided by an IHCP provider.

Members shall not use POWER Account funds to pay for the emergency room services co- payment described in Section 6.6.2 or HIP Basic co-payments described in Section 4.1.2.

5.3 Provider Reimbursement and the POWER Account

Participating providers shall be reimbursed at no less than HIP rates (i.e., a rate established by OMPP that is comparable to Medicare rates or 130% of Medicaid) when a member purchases covered services with POWER Account funds. When sufficient funds exist in the member's POWER account, the entire payment is deducted from the POWER account.

However, if there are insufficient funds in the member's POWER Account, the Contractor must cover the service in full. In these cases, the Contractor can recover any funds it pre-pays on the member's behalf with future POWER Account contributions paid by the member.

5.4 POWER Account Balance Information

The Contractor shall maintain up-to-date member POWER Account balance information. This information shall be mailed to members on a monthly basis in the form of a POWER Account Statement. The POWER Account Statement shall include the member's Gateway to Work status in a format prescribed in the MCE Policy and Procedure manual. It shall also be available online via a secure member portal. The information shall reflect real-time changes in the member's POWER Account, as evidenced by paid claims. It shall also indicate the member's annual and monthly contribution amounts and the State's estimated annual contribution amount.

POWER Account balance information shall also be available to members by contacting the Contractor's Member Helpline.

The Contractor shall give members an opportunity to elect to receive e-mail alerts about updated POWER Account balance information on the member's secure member portal, in addition to or as an alternative to receiving the information by mail.

In providing the required POWER Account balance information, the Contractor may combine the information with the Explanation of Benefit (EOB) information required in Section 7.4.5 below.

5.5 Interest

Neither members nor the Contractor may retain interest on POWER Accounts. The Contractor shall keep POWER Account funds in a hard interest-bearing deposit account that will earn the bank's prevailing interest rate. The funds shall be kept in a separate account and never comingled. Contractor shall report quarterly on the type of account, balance, and interest rate of accrual to the State. This account should be separate from other funds. On an annual basis at the end of each calendar year, the Contractor shall report in the aggregate the interest accrued on its members' POWER Accounts. The Contractor shall return this amount to the State within sixty (60) calendar days after the end of each calendar year. Interest mechanisms may not prohibit prompt payment of claims.

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

5.6 Audit Requirement

The Contractor shall engage an external entity to conduct an annual audit of its POWER Account operations and administration.

5.7 Member 12 Month Eligibility Period

Members must have their eligibility redetermined by the State every 12 months. Member eligibility redetermination occurs 12 months from the member's HIP start date. The Contractor will receive the member's eligibility redetermination date from the State. The Contractor is responsible for reaching out to members prior to their redetermination to encourage them to complete required redetermination paperwork.

In the first month of the member's new eligibility period, HIP Basic members will receive a Potential Plus determination as outlined in Section 3.2.1. The assignment of Potential Plus will provide members with the opportunity to move from HIP Basic to HIP Plus by making their POWER Account contribution or fast track payment.

If a member is determined to remain eligible for HIP at the end of an eligibility period, the member's POWER Account contribution will need to be verified. The State will update the member's POWER Account contribution as necessary based on any changes in the member's income recognized during redetermination. POWER Accounts follow the calendar year benefit period (January through December) and do not mirror the eligibility period.

Members that do not complete their annual 12 month eligibility redetermination will be subject to a six (6) month lockout. For the initial three (3) months following the termination of coverage these members may reenter HIP by providing the required information. For the subsequent three (3) months, members that fail to complete a redetermination are locked out of HIP participation.

5.8 Roll Over

At the end of a calendar year benefit period, members shall have the opportunity to roll over funds from the current calendar year's POWER account to the next calendar year's POWER account. For members that continue enrollment in HIP, any member contributed funds remaining in the member's POWER Account may be used to offset the member's required POWER Account contribution in the subsequent calendar year benefit period. The amount rolled over or discounted shall depend on whether the member was in HIP Plus or HIP Basic at the end of the previous calendar year, and if the member received his or her recommended preventive care services. To allow a claims run-out period, the rollover/ discount calculation shall occur no later than one hundred and twenty (120) calendar days following the end of the calendar year benefit period.

In performing the POWER Account roll over function, the Contractor shall comply with the procedures set forth in this section, as well as all additional policies and procedures included in the HIP MCE Policies and Procedures Manual. The Contractor shall be required to comply with the requirements set forth in these documents as of the effective date of the Contract. The Contractor shall have the capability to transmit the required roll over data electronically as of the effective date of the Contract. This capability will be tested during the readiness review.

5.8.1 Recalculation of Member Contributions

The State fiscal agent will notify the Contractor of the member's POWER Account

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contribution for the new benefit period. After the 12 month calendar year reconciliation period, the Contractor shall report any applicable POWER Account rollover amounts determined in accordance with Section 5.8.2.1 or any discounts determined in accordance with Section 5.8.2.2 to the State fiscal agent on the POWER Account Reconciliation file (PRF), as set forth in Sections 5.8.2 and 5.8.3 below. The Contractor shall notify members of any roll over amounts, as well as any changes in their monthly POWER Account contribution due to roll over amounts or discounts applied. If a HIP Basic or HIP State Plan Basic member is eligible for a discount for participation in HIP Plus, the Contractor shall notify the member of the opportunity to transfer to HIP Plus benefits or HIP State Plan Plus at the discounted rate.

Due to the fact that the first POWER Account installment in the new calendar year benefit period may become due before the member's individual contribution has been recalculated by the State, the member may be billed by the Contractor according to the required contribution schedule. However, the Contractor will be required to reconcile any overpayments or underpayments made by the member after being notified by the State of the member's rollover amount or discount for the new benefit period.

5.8.2 POWER Account Roll Over

Where a member has funds remaining at the end of the calendar year benefit period, some of the funds remaining in the member's POWER Account may be rolled over into the next calendar year benefit period for purposes of reducing the member's required HIP Plus or HIP State Plan Plus POWER Account contributions. Only member rollover dollars can be applied to the tobacco surcharge. Roll over is applied to the member's new account 121 days following the end of the calendar year benefit period.

The amount of leftover funds available for roll over will depend on the member's contributions to the POWER Account, the balance remaining in the member's POWER Account, any member debt, and the member's receipt of recommended preventive care services. For each benefit period, OMPP will determine, based on Centers for Disease Control recommendations, which recommended preventive care services apply to a specific member's age and gender, as well as the member's pre-existing conditions.

POWER Accounts are designed to encourage preventive care, the appropriate utilization of health care services and personal responsibility. The Contractor shall develop multiple methods of emphasizing to members that responsible use of POWER Account funds, as well as obtaining recommended preventive care services, can lead to a reduced financial burden in the next benefit period. If members are aware that prudent management of their health care expenditures can leave them with available funds at the end of the calendar year benefit period—and that these funds can be used to lower their contribution requirements for the following benefit period— members will be encouraged to make value- and cost-conscious decisions. See Section 7.4.4 for required POWER Account member education responsibilities.

The Contractor may collect any member debt from the member portion of roll-over funds determined in accordance with the roll-over calculations detailed in Sections 5.6.2.1 and 5.6.2.2. Under no circumstances shall State roll-over funds be used to pay member debt. In collecting member debt from roll-over funds, the Contractor shall comply with the specific calculations established in the HIP MCE

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

Policies and Procedures Manual.

5.8.2.1 HIP Plus Roll-Over

HIP Plus members and HIP State Plan Plus members who consistently contribute to their POWER account during the calendar year benefit period will be eligible to roll-over the member's unused pro rata share of the POWER Account balance.

If a HIP Plus member or HIP State Plan Plus member receives any recommended preventive care service during the calendar year benefit period, the member will be eligible to have their unused share, or "roll-over amount", doubled by the State as an added incentive. Depending on the balance in the POWER Account, this roll-over amount may significantly reduce or even eliminate the member's required contributions in future benefit periods.

Any remaining State funds shall be credited back to the State.

The roll-over amounts for HIP Plus members and HIP State Plan Plus members are calculated as follows:

1. First, the member's portion of the remaining POWER Account balance (the Member Share) is determined by the following formula:

   Divide the sum of member incurred month POWER account contributions *by* 2,500 (the fully funded POWER account total)

2. Second, the Base Roll-Over Amount is determined as follows:

   Member Share (from #1) *multiplied by* the claims paid from the POWER account. This is the member's claims responsibility for the year. Any payments made by the member in excess of their claims responsibility can be rolled over to the next calendar year.

   Subtract this from the sum of required monthly contributions paid by the member.

   Where the result is positive this is the member's Base Rollover Amount. Where the result is negative the member has debt.

3. Finally, the Final Roll-Over Amount is determined based on whether the member obtained recommended preventive services. The preventive services bonus is applied to the Base Roll-Over Amount as follows to determine the Final Roll-Over Amount:

   If preventive services are completed during the

   plan year: Base Roll-Over Amount x 2 = Final Roll-

   Over Amount

   If preventive services are not completed during the

plan year: Base Roll-Over Amount x 1 = Final Roll-

Over Amount

Consider the following example:

A member who contributes $120.00 over 12 months of enrollment ($10 per month) to the POWER Account over the course of a benefit period and the State contributes $2,380 for a combined contribution of $2,500 ($120 + $2,380 = $2,500). Under the scenario, the member's pro rata share of the total POWER Account is .048 (120/2500).

The member spends $2,100 of POWER Account funds to pay for covered services during the benefit period. At the end of the benefit period, $400 remains in the member's POWER Account (2,500 - $2,100 = $400).

If the member did not obtain any of the preventive care services recommended by OMPP for the member's age, gender and pre-existing conditions before the end of the benefit period, only the member's pro rata share of the remaining POWER Account balance will be rolled over. In this case, the member's pro rata share would be $19.20 (the member's share as determined above- .048 x $400). This $19.20 will be available to be rolled over and applied to the member's required POWER Account contributions in the subsequent benefit period. The $19.20 is rolled over to the subsequent account functions as a credit towards the member's current POWER account contribution responsibility.

If the member obtained any of the preventive care services recommended by OMPP for the member's age, gender and pre-existing conditions before the end of the benefit period, the roll over amount calculated in the previous example would be doubled. The base roll over amount of $19.20 would be multiplied by a factor of 2, or a total roll-over amount of $36.04 is rolled over to the subsequent account functions as a credit towards the member's current POWER account contribution responsibility.

Since roll over occurs one-hundred and twenty (120) days after the start of the subsequent benefit period, the roll-over amount in both scenarios above would be applied as a credit on the member's account. If the roll over amount calculated is in excess of the member's required POWER Account contribution for the next benefit period, the excess amount will be credited as specified in the HIP MCE Policy and Procedure Manual.

5.8.2.2 HIP Basic Roll Over

HIP Basic members and HIP State Plan Basic members who did not contribute to their POWER accounts will not have the ability to "roll-over" funds, since they did not participate in funding the POWER account. However, HIP Basic members and HIP State Plan Basic members will still maintain the incentive to manage the POWER account judiciously and receive recommended preventive care services, as such members may be eligible for a HIP Plus discount directly related to the percentage of the POWER Account balance remaining at the end of the plan year. For

example, if a member has 40% of their POWER account balance remaining at the end of the benefit year, the member may reduce their required HIP Plus contribution by 40% in the following year, provided the member has received their recommended preventive services. However, in no event may a member receive greater than a fifty percent (50%) discount in the subsequent benefit year.

The roll-over amounts for members participating in the either HIP Basic or HIP State Plan Basic are calculated as follows:

1. First, the Roll-Over Percentage is calculated by the following formula: Remaining balance in the POWER account

   Divided by 2,500 (the fully funded POWER account total)

   Multiplied by 100 to yield a percentage < = 50%

2. The determination of the Final Discounted Contribution amount for participation in the HIP Plus plan for the subsequent year would be determined as follows:

   Required contribution for the subsequent year based on FPL

   Minus [Roll-over Percentage *multiplied by* the required contribution]

   Consider the following example:

   > A member on HIP Basic, does not contribute to the POWER Account. However, through actively managing the account, the member only spends $2100 of the POWER Account funds to pay for covered services during the benefit period. At the end of the benefit period, $400 remains in the member's POWER Account ($2500 - $2100 = $400).

If the member did not obtain any of the preventive care services recommended by OMPP for the member's age, gender and pre-existing conditions before the end of the benefit period, the member would not be eligible for any HIP Plus discount in the subsequent year. The member would be offered the opportunity to transfer to HIP Plus one time at eligibility redetermination with a $10.00 per month contribution requirement. The Contractor shall credit the full remaining POWER balance of $400 to the State.

If the member obtained any of the preventive care services recommended by OMPP for the member's age, gender and pre-existing conditions before the end of the benefit period, the rollover would be calculated by dividing the remaining balance in the account ($400) by the full amount of the account ($2,500). This amount is then multiplied by one hundred (100) to yield a percentage, which in this scenario is 16%. This discount is then applied to the contribution required for the member's HIP Plus participation. If the member's contribution amount to transfer to HIP Plus was $10.00 per month, the 16% discount would reduce the required monthly contribution to $8.40. The state will fund the discount provided to

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member's who receive a discount and are enrolled in HIP Plus coverage.

In accordance with Section 5.8.1, the Contractor shall notify the State fiscal agent of the applicable member roll-over discount. Where applicable the state will provide the member the opportunity to move to HIP Plus benefits. The Contractor shall notify the member of the available discount, and provide the member the opportunity to begin making POWER Account contributions and transfer to HIP Plus benefits, or to HIP State Plan Plus cost- sharing, as applicable.

5.8.3 Recommended Preventive Care Services

Annually, OMPP will determine which recommended preventive services qualify a member for roll over or discount. The Contractor shall send preventive service reminders to their members throughout the benefit period, including in the monthly POWER Account Statements and redetermination correspondence.

The Contractor shall have mechanisms in place to monitor when a member has obtained the preventive care services recommended for his or her age and gender, as well as pre-existing conditions, and report this information on the PRF one hundred and twenty (120) calendar days following the end of the member's benefit period.

The Contractor shall monitor whether a member has received recommended preventive care services by:

1. Utilizing claims data to determine if any of the certain specified disease conditions exist;

2. Utilizing claims data to determine if required services have been obtained (OMPP shall provide the qualifying CPT and/or ICD-10 codes, as applicable); and

3. If, after #1 and #2, preventive services cannot be verified, the Contractor may require the member to submit verification of preventive services.

Members will only be required to complete disease-specific preventive services if they were diagnosed with the disease prior to the beginning of the benefit period. If a disease develops mid-benefit period, the member will not be required to complete preventive care services related to that disease until the next benefit period.

Ninety (90) calendar days prior to the end of a member's benefit period, the Contractor shall make an initial assessment (through claims and other information, as described above) of whether the member has completed the recommended preventive services. If the member has not received recommended preventive services, the Contractor shall send a reminder to the member. The reminder shall notify the member that the Contractor's records indicate that the member **has not** received recommended preventive services based on medical claims received as of a specified date. A general listing that outlines what was required for different ages, genders and disease types is sufficient, it does not need to be specific to the member. The reminder shall also explain the appropriate roll-over

incentive based on the member's benefit plan that the member would be eligible to receive in the subsequent benefit period following completion of any recommended preventive service. This correspondence should be coordinated with other redetermination reminders and shall be provided no later than sixty (60) calendar days prior to the end of the member's benefit period.

Sixty (60) calendar days after the end of a member's benefit period, the Contractor shall make an assessment (through claims and other information, as described above) of whether the member has completed the recommended preventive services. The Contractor shall send a letter to the member informing the member of its assessment if the assessment indicates that the member has not received the recommended preventive care. This letter shall go out within the sixty (60) calendar day period.

1. The letter to the member does not need to spell out what services the member received and what were not received. The letter shall only indicate that the required preventive care services were not completed.

2. The letter to the member shall list what the required preventive care services were for the member's benefit period. A general listing that outlines what was required for different ages, genders and disease types is sufficient, it does not need to be specific to the member.

3. The Contractor shall develop a form that can be easily completed by a member's physician which verifies that the member's age and sex appropriate services have been obtained. This form shall be included in the letter to the member.

4. If the Contractor's records indicated that the member has not received the recommended preventive services, the Contractor shall allow the member to file a grievance on the decision by submitting documentation that indicates that they did in fact receive the required preventive care. The form included in the member's letter can be used as supporting documentation, but shall be completed by the member's physician.

5. The letter shall indicate that the member has sixty (60) calendar days from receipt of the letter to file a grievance on the decision and submit additional information using the attached form. The Contractor may incorporate this grievance process into its existing grievance and appeals process, but shall ensure that the grievance is resolved in a time period that allows for timely submission of a complete and accurate PRF to the State.

6. If a member changes MCEs during their annual open enrollment period, the Contractor (e.g., original MCE) is responsible for resolving any grievances related to preventative care services.

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

i. The required preventive service(s) for the year was "X".

- *For HIP Plus members*: Because you regularly contributed

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to your POWER Account throughout the year, you are eligible to roll-over your unused share of the remaining POWER Account balance. If you also received the required preventive services, your "roll-over amount" will be doubled by the State in order to further reduce the cost of the plan in the next benefit period.

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

ii. A preliminary review of our records indicates that you have not received the required preventive service(s).

iii. If you believe our preliminary determination is in error and you have received the preventive services listed above, please fill out the attached form and submit it to "X". The form shall be filled out by your physician and returned within thirty (30) calendar days.

Further detail regarding preventive service monitoring and reporting is set forth in the HIP MCE Policies and Procedures Manual.

5.8.4 POWER Account Reconciliation

Effective January 1, 2018 POWER Accounts transition from alignment with the member's eligibility period to the calendar year. The member's POWER Account covers the first $2,500 of eligible services in each calendar year. Members that continue enrollment in HIP for multiple calendar years have a POWER account assigned to them for every calendar year in which they are enrolled. Where a member leaves HIP and then reenters the program within the same calendar year, the member's POWER account is reactivated. To allow for claims runout, one hundred and twenty (120) days following the end of the calendar year, the POWER account is reconciled with the state. The Contractor shall submit an initial reconciliation for the member rollover thirty (30) days after the end of their benefit period.

During the one hundred and twenty (120) calendar day reconciliation period, the Contractor shall notify the State of whether the member obtained the recommended preventive services and the amount, if any, of either the member's POWER Account that will be rolled over to reduce the next benefit period's required contribution or the percent discount that will be applied to reduce the member's participation in HIP Plus. This notice shall also indicate the amount, if any, of the member's POWER Account that will be credited back to the State and other data as required by the State. This information shall be provided on the PRF, which is an electronic transaction between the Contractor and the State fiscal agent. For POWER accounts requiring reconciliation for benefit periods ending prior to December 31, 2017, the Contractor is required to submit the final reconciliations one hundred and twenty (120) days after the end of the benefit period. See POWER Account technical requirements and the HIP MCE Policies and Procedure Manual.

The Contractor shall be required to comply with these requirements as of the effective date of the Contract.

Member roll over amounts and the State's refunds shall be reported even if the amount is zero, in order to verify to the State that the reconciliation process is finalized. Any amounts reported as owed to the State will be transferred to the State via the 820 transaction. The Contractor may not make adjustments after the PRF is filed one hundred and twenty (120) calendar days following the end of the member's benefit period. Any PRF transactions filed with errors must complete the void and replace process.

The Contractor shall be required to comply with these requirements as of the effective date of the Contract. Reconciliation must be demonstrated at readiness review.

5.9 Termination of Eligibility

If a member becomes ineligible for HIP, either during eligibility redetermination or at another time, the Contractor shall inactivate the member POWER Account. To allow for members that return to the program, the account will be held inactive through the end of the calendar year. One hundred and twenty (120) days following the end of the calendar year, the contractor will refund the State and member share of the remaining POWER Account balance, if any. This Section 5.9 is also applicable when an American Indian/ Alaska Native member elects to opt-out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for-service benefits through the State.

Any prepaid balance in excess of member's pro rata share of the remaining POWER Account balance, as determined in accordance with Section 5.9.1, shall be refunded to the member within thirty (30) days of end of the termination. The State share shall be reported one hundred and twenty (120) calendar days following the end of the calendar year. The Contractor shall submit an initial reconciliation for the member termination thirty (30) days after the end of their benefit period.

In performing the POWER Account reconciliation function when a member loses eligibility, the Contractor shall comply with the procedures set forth in this section and HIP MCE Policies and Procedures Manual. POWER Account technical requirements are updated from time to time. The Contractor shall be required to comply with these requirements as of their effective date. The Contractor shall have the capability to transmit the required reconciliation data electronically as of the effective date of the Contract. This capability will be tested during the readiness review.

5.9.1 Member Refund

If a member becomes ineligible for HIP, either during redetermination or at another time, the Contractor shall refund the member's pro rata share of his or her POWER Account balance, if any, **within one hundred and twenty (120) calendar days** of the member's date of termination from HIP. If the Contractor sends a POWER Account refund check to a member and the check is returned to the Contractor because the member cannot be located, the Contractor shall handle the member's unclaimed refund pursuant to Indiana Statute (IC 32-34-1, et seq.).

A deceased member's estate will have a right to the member's pro rata share of his or her POWER Account funds.

Except for members terminating from the program who are subject to non-payment

penalties for such termination as described below, the amount payable to the member shall be determined as follows:

- Step One: Determine the amount of POWER account contributions owed by the individual for the months of enrollment in HIP Plus or HIP State Plan Plus.
- Step Two: Divide the amount determined in Step One by 2500.
- Step Three: Multiply the ratio determined in Step Two by the total amount spent from the POWER Account
- Step Four: Subtract the amount determined in Step Three from the member paid to Contractor for months enrolled in HIP Plus. Where the result is positive the member is owed a refund of that amount. Where the result is negative the member may owe a debt and is not due a refund.

A member who does not otherwise meet any of the exceptions listed in Section 4.7.1 will be subject to a penalty on the member's refund amount if such member is either terminated from HIP due to non-payment or voluntarily withdraws from HIP prior to the end of the member's benefit period. Such member will forfeit to the State twenty-five percent (25%) of his or her pro rata share of any funds remaining in the member's POWER Account. This means that upon member termination from HIP due to non-payment, the Contractor shall be required to refund only a portion of the member's pro rata share of the POWER Account. In certain instances, the State may waive the application of the penalty. Where there is a penalty assessed, the amount payable to the member shall be determined as follows:

- Step One: Where the amount determined in Step Four of the previous section is positive, multiply this amount by .75.
- Step Two: Refund the member the amount calculated in Step One. Refund the State the amount of the member penalty.

5.9.2 State Refund

Any funds remaining in the POWER Account after the member rebate shall be credited to the State via the 820 transaction. The Contractor will have one hundred and twenty (120) calendar days from the end of the calendar year to report the amount to the State.

5.9.3 POWER Account Reconciliation

In the event of member termination, the POWER Account reconciliation process occurs as below:

- Member refund: Prepaid months where the member is no longer enrolled must be refunded 30 calendar days after the member termination.
- State refund: One-hundred and twenty (120) calendar days from end of the calendar year

One hundred and twenty (120) calendar days following the end of the calendar year , the Contractor shall notify the State fiscal agent of the amount of the member and

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state refunds and other data set forth in the PRF File Layout. This information shall be provided on the Power Account Reconciliation File (PRF), which is an electronic transaction between the Contractor and the State fiscal agent.

Member and state refunds shall be reported even if the amount is zero, in order to verify to the State that the reconciliation process is finalized. Any amounts reported as owed to the State will be transferred to the State via the 820 transaction.

Once the final PRF is filed one hundred and twenty (120) calendar days following the end of the calendar year, the Contractor may only make adjustments via the void process at the approval of the State. The Contractor shall be responsible for any claims received after the POWER Account has been reconciled and/or member refund has been issued. All missing POWER Account payment and capitation must be reported to the Indiana Medicaid fiscal agent and OMPP and reconciled no later than two years following the end of the benefit period. The Contractor shall not pursue the member's portion of an appealed claim after a member refund is made.

The Contractor shall be required to comply with these requirements as of the effective date of the Contract. POWER Account Reconciliation for benefit periods ending prior to December 31, 2017 shall follow the policy and procedures documented in the MCE Policy and Procedures Manual. OMPP will provide a timeline prior to reconciliation start date so that adjustments to the required submission timeframes can be made as needed. Reconciliation must be demonstrated at readiness review.

5.10 POWER Account Debt Collection Process

Members may incur debt to the MCEs through missed POWER account payments.

Notwithstanding the foregoing, member debt may not exceed the following amounts:

(1) For members with household income above one hundred percent (100%) of the FPL, an amount that does not exceed ten percent (10%) of the cost of services received; or

(2) For members with household income at or below one hundred percent (100%) of the FPL, an amount that does not exceed the sum of the unpaid required monthly contributions during months in which the member received HIP Plus coverage but was not contributing to the POWER Account.

The Contractor may register and collect any debt owed by the member to the Contractor. The Contractor shall register the debt with the State fiscal agent. The State fiscal agent will document the debt owed and the MCE to whom the debt is owed. If the Contractor pursues the member debt, the Contractor shall do so in accordance with standard company practice for collection of debt in the individual market segment. However, the Contractor shall not (i) sell the member's debt, (ii) report the debt to credit reporting agencies, (iii) place a lien on the member's home, (iv) refer the case to debt collectors, (v) file a lawsuit, or (vi) seek a court order to seize a portion of the member's earnings. The Contractor may collect member debt from member rollover dollars. Any member debt collected by the Contractor shall be included in the member's quarterly five percent (5%) cost sharing maximum described in Section 6.16.

The Contractor shall comply with the debt collection policies and procedures set forth in HIP MCE Policies and Procedures Manual. The Contractor shall be required to comply with the requirements set forth in the document as of the effective date of the

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Contract.

5.11 POWER Account Balance Transfers

If a member transfers to another MCE during their benefit period, the Contractor shall submit an informational PRF to the State fiscal agent within thirty (30) calendar days of notification of the transfer, which shall include POWER Account balance information (including member contribution paid and POWER Account claims paid) for the new MCE, as applicable. The Contractor shall also submit a final PRF to the State fiscal agent within one hundred twenty (120) calendar days of notification of the transfer in order to close out the member's POWER account and transfer any remaining funds in a manner and method prescribed by the State.

If the member transfer occurs at the end of the calendar year benefit period, the Contractor remains responsible for determining the amount of member roll over, as well as any amounts that shall be credited back to the State. The Contractor will be required to forward the roll over amount to the State and credit to the State its share of the POWER Account balance, as described above. The Contractor must accept inbound PRF transactions when members transfer at the end of the calendar year. The Contractor must apply the member's payments and rollover to the POWER Account for the calendar year.

The Contractor shall comply with the MCE transfer policies and procedures set forth in HIP MCE Policies and Procedures Manual as well as the POWER Account technical requirements. The Contractor shall be required to comply with the requirements set forth in the documents as of the effective date of the Contract.

6.0 Covered Benefits and Services

The Contractor shall provide to its HIP members, at a minimum, all benefits and services deemed "medically reasonable and necessary" and covered under the Contract with the State. A covered service is medically necessary if it meets the definition as set forth 405 IAC 10-2-1(30).

The Contractor shall deliver covered services sufficient in amount, duration or scope to reasonably expect that provision of such services would achieve the purpose of the furnished services. Costs for these services are the basis of the Contractor's capitation rate and are, therefore, the responsibility of the Contractor. Coverage may not be arbitrarily denied or reduced and is subject to certain limitations in accordance with 42 CFR 438.210(a)(4), which specifies when Contractors may place appropriate limits on services, regarding:

- Medical necessity determinations.
- Utilization control, provided the services furnished are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.

6.1 Covered Benefits and Services

HIP covered services include all services, including coverage criteria, limitations and procedures, identified in the HIP alternative benefit plans (ABP) approved by CMS and meeting the requirements as set forth in Section 1937 of the Social Security Act. In the event the requirements of any HIP alternative benefit plan as approved by CMS conflicts with any of the terms of this Contract, the requirements of the alternative benefit plan shall prevail. Exhibit 6 of the Contract provides a general summary description of the different HIP benefit packages and the services and benefits that are available under

each.

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

In addition, HIP will cover additional pregnancy-only benefits which will only be available for pregnant HIP members enrolled in either the HIP Plus or HIP Basic plans. The additional pregnancy-only benefits are specified in the applicable ABP and include such services as non- emergency transportation, chiropractic manipulations, vision and dental.

The Contractor shall reimburse both in- and out-of-network HIP providers for covered services at a rate not less than 1) Medicare reimbursement or 2) 130% of Medicaid rates if the service does not have a Medicare reimbursement rate. Pursuant to 405 IAC 10-8-1(b), in instances where the Contractor pays for a service at the Medicare rate, any cost-sharing typically applicable in the Medicare program is not applicable and will be included in the rate paid by the Contractor. However, in instances where the Contractor pays for a service provided to a HIP Basic member, the Contractor shall exclude the amount of the required HIP Basic copayment from the rates paid to the provider.

6.2 Self-referral Services

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

The Contractor shall include self-referral providers in its contracted network. The Contractor and its PMPs may direct members to seek the services of the self-referral providers contracted in the Contractor's network. However, with the exception of behavioral health and routine dental services, the Contractor cannot require that the members receive such services from network providers.

With the exception of family planning services and emergency services, when HIP members choose to receive self-referral services from IHCP-enrolled self-referral providers, they shall go to an in-network provider or receive prior authorization to go to an out- of-network provider. The Contractor is responsible for payment for self-referral services up to the applicable benefit limits and at a rate of 100% of the Medicare rate or 130% of Medicaid if there is no Medicare rate for in-network providers.

Members may not self-refer to a provider who is not enrolled in IHCP. The following services are considered self-referral services. The Indiana Administrative Code 405 IAC 5 and 405 IAC 9-7 (HIP) provides further detail regarding these benefits.

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

pregnancy-only benefits. Chiropractors may provide other therapy services in their scope of practice to all HIP members.

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

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

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

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

- Family planning services under federal regulation 42 CFR 431.51(b)(2) require a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. 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.

Under the Contractor's HIP line of business, the Contractor shall provide all covered family planning services and supplies. Emergency services are covered without the need for prior authorization or the existence of a Contractor contract with the emergency care provider. Emergency services shall be available twenty four (24)-hours-a-day, seven (7)-days-a-week subject to the "prudent layperson" standard of an emergency medical condition, as defined in 42 CFR 438.114, which relates to emergency and post-stabilization services, and IC 12-15-12. See Section 6.6 for more information.

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

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

- Diabetes self-management services are self-referral if rendered by a self-referral provider. See Section 6.10 for more detail.

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

  - Outpatient mental health clinics;
  - Community mental health centers;
  - Psychologists;
  - Certified psychologists;
  - Health services providers in psychology (HSPPs);
  - Certified social workers;
  - Certified clinical social workers;
  - Psychiatric nurses;
  - Independent practice school psychologists;
  - Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center; and
  - Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option).

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

EPSDT is a federally-mandated preventive health care program designed to improve the overall health of Medicaid-eligible infants, children and adolescents from birth to twenty-one (21) years old. HealthWatch is the name of Indiana's EPSDT program. HealthWatch includes all IHCP- covered preventive, diagnostic and treatment services, as well as other prior-authorized treatment services that the screening provider determines to be medically necessary. In addition, EPSDT services include the provision of medically necessary services to members less than twenty-one (21) years old in institutions of mental disease (IMDs).

The primary goal of 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 HealthWatch EPSDT Provider Manual for details regarding components and recommended frequency of HealthWatch screenings.

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

HIP members 19 and 20 years of age may be covered by EPSDT.

6.4 Pharmacy Benefits

Prescription drugs are a benefit under the HIP program to be covered by the Contractor. The Contractor shall support FSSA in promptly responding to public and legislative inquiries involving the design and management of the Contractor's pharmacy benefit. If the Contractor elects to subcontract with a PBM, the Contractor shall ensure compliance with all subcontracting requirements outlined in Section 2.7, including but not limited to

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conducting regular audits and monitoring of the subcontractor's data and performance, as well as requiring their PBM to conduct regular audits of their pharmacy provider networks.

The Contractor shall not be responsible for member pharmacy claims incurred prior to the effective date of this contract.

The Contractor shall, at the direction of the Secretary, implement specified fee-for-service PDL and/or prior authorization, if unified PDL is not implemented.

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

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

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.

The Contractor shall assure proper and complete PBM agent training.

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

6.4.1 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 Organization. To facilitate collection of these rebates, FSSA shall include utilization data of HIP MCEs when requesting quarterly rebates from manufacturers as well as in quarterly utilization reports to CMS. Thus, the Contractor shall timely submit their pharmacy encounter data completely and accurately to the State, in a manner required 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. The State intends to use and share the Contractor paid amount information on the State's pharmacy claim extracts for rebate purposes. Requirements for pharmacy encounter claims are outlined in Section 11.6.

The report will include information on the total number of units of each dosage form, strength and package size by National Drug Code (NDC) of each covered outpatient drug dispensed to Contractor members and such other data that the Secretary of CMS determines necessary for the State to access rebates. This reporting shall include physician- administered drugs. For more information on reporting, please refer to Section 12, as well as the HIP MCE Reporting Manual.

The Contractor shall comply with 340B-related policies and procedures set forth in IHCP Provider Bulletin BT201754, and any updates thereto. The Contractor shall monitor claims for provider compliance of federal and state billing requirements pertaining to 340B-sourced drugs. The Contractor shall, at the request of the State,

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require providers to use 340B claims modifiers the State deems necessary to accurately assess rebates.

Additionally, the Contractor shall assist OMPP or the State's PBM Contractor in resolving drug rebate disputes with the manufacturer.

6.4.2 Preferred Drug List and Formulary Requirements

The Contractor shall maintain a preferred drug list (PDL) for the Contractor's HIP program.

The HIP formulary shall support the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in 405 IAC 5-24-3. 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 process 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.

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

Therefore, the HIP Basic pharmacy benefit may have more restrictions than the HIP plus benefit, such as limiting prescription supplies to 30 days. Also, prescriptions obtained by a HIP Basic or HIP State Plan Basic member that are not otherwise exempt on the basis of being preventive, family planning, or maternity, are subject to the copayment amounts set forth in Section 4.1.2. Copayments assessed to the HIP Basic or HIP State Plan Basic member at the point of sale may not exceed the total cost of the drug.

Similarly, the HIP Plus pharmacy benefit shall provide additional enhanced pharmacy services including the following: (i) ninety (90) day prescription supplies of routine maintenance medications, when requested by the member; (ii) mail order pharmacy benefit; (iii) and no copayment for any filled prescription. These additional pharmacy services shall only be made available to individuals participating in HIP Plus and HIP State Plan Plus benefits.

Prior to implementing a PDL or formulary, the Contractor shall: (i) submit the PDL or formulary to OMPP for submission to the Drug Utilization and Review (DUR) Board; and (ii) receive approval from OMPP in accordance with IC 12-15-35-46.

At least thirty-five (35) days before the intended implementation date of the PDL and formulary, the Contractor shall submit its proposed PDL and formulary to OMPP. The OMPP shall submit the PDL and formulary to the Drug Utilization Review (DUR) Board for review and recommendation. The Contractor shall be accessible to the DUR Board to respond to any questions regarding the PDL and formulary. The DUR Board will provide a recommendation regarding approval of the PDL and formulary in accordance with the terms of IC 12-15-35-46. OMPP will approve, disapprove or modify the PDL and/or 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.

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

Contractors implementing a common or “unified” PDL will participate in all aspects of Indiana Medicaid’s Therapeutics Committee deliberations. The Contractor shall utilize a Pharmacy and Therapeutics Committee which shall meet regularly to make recommendations for changes to the PDL and/or formulary. In accordance with IC 12-15- 35-47, prior to removing one (1) or more drugs from the PDL and/or formulary or otherwise placing new PA criteria on one (1) or more drugs, the Contractor shall submit the proposed change to the OMPP 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 OMPP staff, as directed by OMPP, to answer questions about the clinical rationale for the proposed change. The DUR Board will provide a recommendation regarding approval of the proposed change to the PDL and/or formulary in accordance with the terms of IC 12-15-35-47. OMPP will approve, disapprove or modify the PDL and/or formulary based on the DUR Board’s recommendation. The Contractor is not required to seek approval from the State in order to add a drug to the PDL or formulary; however, the Contractor shall notify the OMPP of any addition to the PDL and/or formulary within thirty (30) days after making the addition.

The PDL and formulary shall be made readily available to providers in the Contractor’s network and to members. The PDL and formulary shall be updated to reflect all changes in the status of a drug or addition of new drugs. The Contractor shall also support e- Prescribing technologies to communicate the PDL and formulary to prescribers through electronic medical records (EMRs) and e-Prescribing applications. See Section 6.4.5 for additional requirements on e-Prescribing. Consistent with the requirements of Section 8.7, the Contractor shall develop provider education and outreach aimed at educating providers about the HIP PDL and formulary as well as the utilization of e-Prescribing technologies to ensure appropriate prescribing for members based on the member’s benefit plan.

The Contractor must consider, in its proposal, using the State’s PDL for all of its pharmacy plan benefits and to contract with the State’s PBM contractor for all pharmacy claims processing. The Contractor shall be permitted to utilize the work of the Therapeutics Committee and DUR Board in maintaining the State’s PDL for the Contractor’s HIP State Plan benefits.

Assure that non-drug products approved for use in compounding are not subject to rebating manufacturer requirements.

6.4.3 DUR Board Reporting Requirements

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

- An analysis of the single source drugs requiring prior authorization in comparison to other contractor’s prescription drug programs in the HIP program.
- A determination and analysis of the number and the type of drugs subject to a restriction.
- A review of the rationale for the prior authorization of a drug and a restriction on a drug.

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

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

The Contractor shall provide OMPP with the information necessary for the DUR Board to conduct this review in the timeframe and format specified by OMPP. In addition to the DUR Board approval, the Contractor shall also seek the advice of the Mental Health Medicaid Quality Advisory Committee, 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 supply, on a quarterly basis, a report to the Office and the DUR Board of the number of member days of missed therapy due to prior authorization. The format of this report will be agreed upon by the Contractor, the Office and the DUR Board. In addition, the Contractor shall comply with any additional reporting requests required for submission to the DUR Board. Please refer to the HIP MCE Reporting Manual for more information on pharmacy reporting requirements.

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.

6.4.4 Dispensing and Monitoring Requirements

The Contractor shall administer pharmacy benefits in accordance with all applicable state and federal laws and regulations. The Contractor shall comply with the requirements of IC 12-15-35.5-3 in establishing prescribing limits to mental health drugs. 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 supply of a covered outpatient prescription drug in an emergency situation as required under 42 U.S.C 1396r-8(d)(5)(B). The Contractor shall employ an automated system for approval of a 72-hour emergency supply of a restricted drug. The automated system shall allow the pharmacist to dispense the 72-hour supply and then follow-up with the Contractor or provider the next business day.

The Contractor, implementing a unified PDL, shall implement prior authorization approved for all plans, by the DUR Board. The Contractor shall participate in the development and recommendation of PA criteria brought before the DUR Board. If it elects to utilize its own PA process, 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 number drug provided and duration of treatment. The Contractor will be required to have a process in place to allow drugs that are medically necessary but not included on the formulary to be accessed by members. The Contractor will be required to accept prior authorization requests via telephone, fax, web-based system, or in writing. To conform to 42 CFR 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

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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. Independently developed and implemented PA criteria will be displayed, in a common format, alongside fee for service and other Contractor criteria.

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

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

1. The MCE shall regularly report findings on audits performed and outcomes completed by the MCE on it's PBM

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

The Contractor shall monitor their PBM and report to OMPP when the PBM does not meet the following Service Levels:

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

6.4.5 E-Prescribing

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

The Contractor should consider an automated PA process using a rules-based clinical editing algorithm that integrates paid medical and pharmacy claims.

The Contractor agrees to work with OMPP and the fee for service PBM to transition the pharmacy benefit back to the FFS PBM if OMPP decides to implement the FFS pharmacy benefit for HIP members.

6.4.6 Carve-Out of Select Drugs

Exhibit 6 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.

6.4.7 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 by October 1, 2019:

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

6.5 Tobacco Dependence Treatment Services

For HIP State Plan benefits and any member eligible under any HIP category for HIP Maternity benefits (see Section 3.4), the Contractor shall cover, at minimum, tobacco dependence treatment services as set forth in 405 IAC 5-37. Treatment may include prescription of any combination of tobacco dependence products and counseling.

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Providers may prescribe one or more modalities of treatment. Providers shall include counseling in any combination of treatment. For HIP Plus and HIP Basic benefits, the Contractor shall cover the tobacco dependence benefits described in the Alternative Benefit Plan. See Exhibit 6 of this Contract for more information.

6.6 Emergency Care

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 the Medicare rate or, if there is no Medicare rate, at 130% of Medicaid 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. Effective February 1, 2020 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 will conduct a prudent layperson review to determine whether an emergency medical condition exists, the reviewer shall not have more than a high school education and shall 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.

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Effective April 1, 2020, 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.

By April 1, 2020 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 hour to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days- a-week. The Contractor will be financially responsible for the post-stabilization services if the Contractor fails to respond to a call from an emergency room provider within one hour.
- A mechanism to track the emergency services notification to the Contractor (by the emergency room provider, hospital, fiscal agent or member's PMP) of a member's presentation for emergency services.
- A mechanism to document a member's PMP's referral to the emergency room and pay claims accordingly.
- A mechanism in place to document a member has made a call to the Contractor's 24-Hour Nurse Call Line twenty four (24) hours prior to an ER visit, and to waive emergency room copayments for HIP members accordingly, as set forth in Section 6.6.2. This includes a mechanism to communicate the copayment waiver to the emergency services provider.
- A mechanism in place to document a member's referral to the emergency room by the Contractor's 24-Hour Nurse Call Line and pay claims resulting from such referral as emergent.
- A mechanism in place to document a HIP member's inappropriate emergency department utilization, and to communicate emergency room copayments for HIP members accordingly, as set forth in Section 6.6.2.

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

- A mechanism and process to accept medical records for a prudent layperson review with an initial claim and after a claim has processed. For dates of service after April 1, 2020 the MCE must at a minimum allow a provider to submit medical records for a prudent layperson review within 120 days of a claim's adjudication.

6.6.1 Post-stabilization

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

6.6.2 Emergency Room Services Co-Payment – HIP

A co-payment will apply to non-emergency use of an emergency room by HIP members. Other than HIP members exempt from cost-sharing as described in Section 4.1.4, all HIP members will be subject to a co-payment for all non-urgent use of hospital emergency department services. The member will incur an $8 co-payment for any inappropriate emergency department visit. Providers will collect the co-payment from members, and POWER Account funds cannot be used by the member to pay the co-payment. The Contractor shall include co-payment information on the member's ID card which directs the provider to call the Contractor for specific co-payment amount due, as the member may have received a copay waiver by calling the Contractor's nurse hotline, as described below.

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

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

Assuming a member has an available and accessible alternate non-emergency services provider and a determination has been made that the member does not have

an emergency medical condition and did call the Contractor's 24-hour Nurse Call Line, in accordance with 42 C.F.R. § 447.54(d), the hospital shall inform the member before providing non-emergency services that:

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

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

6.7 Behavioral Health

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

- Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits.
- Ensuring compliance with MHPAEA for any benefits offered by the Contractor to members beyond those otherwise specified in this Scope of Work.
- Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential members, or contracting provider upon request.
- Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members.
- Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

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

- Provide care that addresses the needs of HIP members in an integrated way,

with attention to the physical health and chronic disease contributions to behavioral health;

- Provide a written plan and evidence of ongoing, increased communication between the PMP, the Contractor and the behavioral health care provider; and
- Coordinate management of utilization of behavioral health care services with MRO and 1915(i) services and services for physical health.

6.7.1 Behavioral Health Care Services

The Contractor shall provide all medically necessary community-based, partial hospital and inpatient hospital behavioral health services as identified in Contract Exhibit 4. Contractors shall pay CMHCs at no less than the Medicare rate or 130% of Medicaid FFS rate for any covered non-MRO service that the CMHC provides to a HIP member.

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

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

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

6.7.2 Behavioral Health Provider Network

FSSA requires Contractors to develop a sufficient network of behavioral health providers to deliver the full range of behavioral health services. The network shall include psychiatrists, psychologists, clinical social workers and other licensed behavioral health care providers. In addition, Contractors shall provide inpatient care for a full continuum of mental health and substance abuse diagnoses. See Section 8.2 for behavioral health network requirements. All services covered under the clinic option shall be delivered by licensed providers, such as psychiatrists and health services providers in psychology, Advanced Practice Nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling.

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

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Members shall be able to receive timely access to medically necessary behavioral health services. The network shall meet the access requirements specified in Section 8.2.5.

6.7.3 Case Management for Members Receiving Behavioral Health Services

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

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

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

In addition, with the appropriate consent, case managers shall notify both PMPs and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. Case managers shall provide this notification within five (5) calendar days of the hospital admission or emergency treatment.

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

6.7.4 Behavioral Health Care Coordination

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

The Contractor shall share member medical data with physical and behavioral health providers and coordinate care for all members receiving both physical and behavioral health services, to the extent permitted by law and in accordance with

the member's consent, when required. The Contractor shall contractually mandate that its behavioral health care network providers notify the Contractor within five (5) calendar days of the member's inpatient visit and within five (5) days of a member's initial referral 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 the Health Insurance Portability and Accountability Act (HIPAA) and state law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance abuse records. The Contractor shall contractually require every network provider, including behavioral health providers, to ask and encourage members to sign a consent that permits release of substance abuse treatment information to the Contractor and to the PMP or behavioral health provider, if applicable.

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

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

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

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

The Contractor shall implement mechanisms to ensure coordination among member's providers. With appropriate consent, the Contractor shall notify behavioral health providers and medical providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. This notice must be provided within five (5) calendar days of the hospital inpatient admission or emergency treatment. The Contractor shall maintain a description of strategies proposed to receive hospital notification of inpatient admissions to facilitate meeting the requirement for example, through the use of incentive programs. The Contractor shall develop additional mechanisms for facilitating communication between behavioral health and physical health providers to ensure the provision of integrated member care. Incentive programs, case managers, behavioral health profiles, etc. are potential mechanisms to ensure care coordination and the reciprocal exchange of health information between physical and behavioral health providers. The Contractor shall require the behavioral health provider to share clinical information directly with the member's PMP. The Contractor shall evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and

implement mechanisms to improve coordination and continuity of care based on monitoring outcomes. Refer to section 6.13 for notification and continuity of care requirements for non-behavioral health admissions and emergency services.

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

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

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

6.7.5 Behavioral Health Continuity of Care

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

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

6.7.6 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.

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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.

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6.8 Disease Management

The Contractor shall offer, at minimum, asthma, depression, pregnancy, ADHD, autism/pervasive developmental disorder, COPD, coronary artery disease, chronic kidney disease, congestive heart failure, HIV, Hepatitis C and diabetes disease management programs for eligible HIP members. Members with excessive utilization or under-utilization for conditions other than those listed shall also be eligible for the disease management services described in this section. Members with these conditions should be identified through the health needs screening tool described in Section 7.2.3 and by identification of conditions based on claims.

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

The Contractor shall submit quarterly reports to OMPP regarding the selection criteria, strategies, outcomes and efficacy of these and any other disease management programs offered by the Contractor. The quarterly reports shall include participation rates and utilization and cost statistics of both total members enrolled in the disease management programs, as well as HIP medically frail members enrolled in the disease management programs. For example, the diabetes disease management quarterly report will include (i) all medically frail members with two or more claims in the calendar year for diabetes, and the numerator shall include all members with two or more claims in the calendar year for diabetes; and (ii) all members with two or more claims in the calendar year for diabetes, and the numerator shall include those members enrolled in case or care management as defined below. Separate, mutually exclusive calculations for members in case and care management shall be conducted. The reports shall also identify any member at least three (3) standard deviations outside of the mean of utilization of inpatient days, emergency department visits and home health service days for the population group. All disease management programs shall encourage compliance with national care guidelines (e.g., American Diabetic Association) and incentivize healthy member behaviors. All members shall be sent population-based disease management materials (e.g., educational fliers, screening reminders, etc.). OMPP believes that the Contractor's disease management programs will serve as a critical area for pursuing continuous innovation in improving member health status, and disease management programs may be subject to onsite visits or external quality reviews.

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

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

OMPP reserves the right to examine the Contractor's disease management programs at any time, including during the proposal review process, prior to Contract execution, during the readiness review and during the term of the Contract.

Disease management consists of three levels of Contractor-member interaction,

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including population-based interventions, care management and complex case management. For the purpose of this Contract, the term care coordination will serve as a global reference for case management, care management, complex case management or any other term referencing the organization, synchronization and/or management of health care services for the benefit of the member. Similarly, the term care manager is used for ease to describe the staff person performing the functions of disease management, case management, care management, or complex case management when organizing, synchronizing and/or managing health care services for the benefit of the member.

Members served in the Contractor's disease management, care management and complex case management services may require additional resources to meet their biopsychosocial needs. To meet these needs, the Contractor shall make every effort to assist members in navigating community resources and linking members with community based services such as Connect2Help211, food pantries, housing and housing supports, legal, employment and disaster services.

6.8.1 Population-Based Interventions

The Contractor shall engage members with the conditions of interest through disease specific and preventive care population-based interventions including educational materials and appointment and preventive care reminders. All pregnant members shall receive standard pregnancy care educational materials, OMPP-approved tobacco cessation materials and access information for 24-Hour Nurse Call Lines. Any given member may be eligible for more than one condition. Materials should be delivered through postal and electronic direct-to-consumer contacts, including Interactive Voice Recordings (IVR), as well as web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. All members with the conditions of interest shall receive materials no less than bi-annually. The Contractor shall document the number of persons with conditions of interest, mailings and website hits.

6.8.2 Care Management

The Contractor's protocol for referring members to care management shall be reviewed by OMPP and shall be based on identification through the health needs screening, member request or when the claims history suggests need for intervention. In addition to population-based disease management educational materials and reminders, these members should receive more intensive services. Members with newly diagnosed conditions, increasing health services or emergency services utilization, evidence of pharmacy non-compliance for chronic conditions and identification of special health care needs should be strongly considered for care management or complex case management. Care management services include direct consumer contacts in order to assist members with scheduling, location of specialists and specialty services, transportation needs, 24-Hour Nurse Line, general preventive (e.g. mammography) and disease specific reminders (e.g. Hgb A1C), pharmacy refill reminders, tobacco cessation and education regarding use of primary care and emergency services.

The Contractor shall make every effort to contact members in care management telephonically. Materials should also be delivered through postal and electronic direct-to- consumer contacts, as well as web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. All members with the conditions of interest shall receive materials no less

than quarterly. The Contractor shall document the number of persons with conditions of interest, outbound telephone calls, telephone contacts, category of intervention, intervention delivered, mailings and website hits. Care management shall be coordinated with the Right Choices Program for members qualifying for the Right Choices Program. However, the Right Choices Program is not a replacement for care management.

6.8.3 Complex Case Management

The Contractor's protocol for referring members to complex case management shall be reviewed by OMPP and shall be based on a member's designation as medically frail, identification through the health needs screening as having special care needs, a condition of interest named above, or a chronic or co-morbid disease utilization history and/or member request that indicates the need for real-time, proactive intervention. Persons with clinical medical training shall be required to develop the member's care plan. The Medical Director shall be available to consult with the clinicians on the care management team as needed to develop the care plans for high risk cases. Care plans developed by the Contractor shall include clearly stated health care goals to address the medical, social, educational, and other services needed by the individual and defined milestones to document progress, clearly defined accountability and responsibility and timely, thorough review with appropriate corrections ("course changes") as indicated. The Contractor's case management services and care plan development shall involve the active management of the member and his/her group of health care providers, including physicians, medical equipment, transportation and pharmacy to help link the member with providers or programs capable of helping the member achieve the defined goals of the care plan. The member's health care providers shall be included in the development and execution of member care plans. Care plans and case management shall take into account co-morbidities being jointly managed and executed, as separate care plans for each medical problem in the same member may fragment care and add to the potential of missing interactive factors.

The Contractor shall contact members telephonically and in-person as indicated by their need. Care managers should engage in care conferences with the member's health care providers, as necessary. Members shall receive the same educational materials delivered to those persons receiving case management including direct consumer contacts in order to assist members with scheduling, location of specialists and specialty services, transportation needs, 24-Hour Nurse Call Line, general preventive (e.g. mammography) and disease specific reminders (e.g. Hgb A1C), pharmacy refill reminders, tobacco cessation and education regarding use of primary care and emergency services. Materials can be delivered through postal and electronic direct-to-consumer contacts, as well as web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. The Contractor shall document the number of persons with conditions of interest, outbound telephone calls to providers and members, telephone contacts to members and providers, category of intervention, intervention delivered, mailings and website hits. Utilization statistics on hospitalizations, emergency services, primary care and specialty care should be documented and trended from baseline. The Contractor's care management services shall be coordinated with the Right Choices Program for members qualifying for the Right Choices Program. However, the Right Choices Program shall not be considered a replacement for care management or complex case management.

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6.9 24-hour Nurse Call Line

The Contractor shall provide nurse triage telephone services for members to receive medical advice twenty-four (24) hours-a-day/seven (7)-days-a-week from trained medical professionals. The twenty four (24)-hour Nurse Call Line should be well publicized and designed as a resource to members to help discourage inappropriate emergency room use, particularly for members in disease management. The 24-hour Nurse Call Line may share location information of nearby urgent care clinics. The 24-hour Nurse Call Line shall have a system in place to communicate all issues with the member's PMP. In addition, as set forth in Section 6.6.2, the 24-Hour Nurse Call Line shall be equipped to provide advice for HIP member's seeking services from hospital emergency departments. The nurse call line shall collect data sufficient to meet program managers, member assistance and reporting needs.

6.10 Other Covered Benefits and Services

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

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

- The Contractor shall provide **prenatal care programs** targeted to avert untoward outcomes in high-risk pregnancies.

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

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

- The Contractor shall provide **Hospice Care**, provided in a facility or in the home, is a covered service. Subject to the limitations and definitions set forth in Indiana Code and in the list of covered benefits.

- The Contractor shall provide **Diabetic Supplies Coverage**. The Contractor shall cover diabetic supplies in alignment with FSSA's Preferred Diabetic Supply List (PDSL). The Contractor shall configure its claims payment system to approve the

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diabetic supplies of FSSA's contracted preferred vendors to supply blood glucose monitors and diabetic test strips for all IHCP enrollees. The Contractor shall adjudicate diabetic supplies through their PBM's point of sale system to ensure that NDCs are on the claim. The Contractor shall require prior authorization for all blood glucose monitors and diabetic test strips not on the PDSL.

6.11 Carved-out Services

Some services are not included in the Contractor's capitation rates for the HIP populations and, therefore, are not the responsibility of the Contractor. These services are referred to as "carved-out" services. The State fiscal agent pays on a FFS basis for carved-out services rendered to the Contractor's members. However, under some circumstances, services related to the carved-out services are the responsibility of the Contractor for reimbursement.

Listed below are the carved-out services in the HIP program and the conditions under which related services are the Contractor's responsibility. The HIP MCE Policies and Procedures Manual describes these carved-out services in greater detail.

6.11.1 Medicaid Rehabilitation Option (MRO) Services

The Contractor is not responsible for claims reimbursement for such services. However, the Contractor is responsible for ensuring care coordination, as described in Section 6.7, with physical and other behavioral health services for individuals receiving MRO services. See the MRO Provider Reference Module for specific codes for MRO services.

6.11.2 1915(i) State Plan Home and Community-Based Services

The State has three (3) 1915(i) State Plan Home and Community-Based services programs: Behavioral and Primary Healthcare Coordination (BPHC), Adult Mental Health and Habilitation (AMHH) and Children's Mental Health Wraparound (CMHW). These services are carved-out of the Contractor's financial responsibility. The Contractor shall coordinate with 1915(i) services to prevent duplication and fragmentation of services. A listing of carved-out 1915(i) services is provided in the respective Provider Reference Modules. As described in Section 6.12.4, some individuals receiving BPHC will be disenrolled from the Contractor.

6.12 Excluded Services

The HIP program excludes some benefits from coverage under managed care. These benefits are available under Traditional Medicaid or other waiver programs and are therefore excluded from the programs as described below. A member who is, or will be, receiving excluded services must be disenrolled from managed care in order to be eligible for these services. The HIP MCE Policies and Procedures Manual describe member disenrollment in greater detail.

Listed below are the services excluded from the HIP program.

6.12.1 Long-Term Institutional Care

HIP members requiring long-term care in a nursing facility or Intermediate Care Facility for the Intellectually Disabled (ICF/ID) must be disenrolled from the HIP program and converted to fee-for-service eligibility in the IHCP. Before the nursing facility can be reimbursed by IHCP for the care provided, the nursing facility must

request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State must then approve the PASRR request, designate the appropriate level of care in *Core*MMIS and disenroll the member from HIP. The Contractor must coordinate care for its members that are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR, as described in the IHCP Provider Manual. 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.

However, the Contractor may obtain services for its members in a nursing facility setting on a short-term basis, i.e., for fewer than thirty (30) calendar days. This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. The Contractor may negotiate rates for reimbursing the nursing facilities for these short-term stays. 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.

6.12.2 1915(c) Home and Community-Based Services (HCBS) Waiver

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

6.12.3 Psychiatric Treatment in a State Hospital

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

6.12.4 Behavioral and Primary Healthcare Coordination (BPHC) Services

Members who become eligible for Medicaid via the BPHC Program through the State's coverage of the optional categorically needy eligibility group under 1902(a)(10)(A)(ii)(XXII) will be disenrolled from HIP. As described in Section 6.11.2, individuals eligible to receive BPHC services who are otherwise eligible for a HIP eligibility category will remain enrolled with the Contractor but the Contractor shall not be financially responsible for reimbursement of the BPHC service.

6.13 Continuity of Care

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

- Transitions for members receiving HIV, Hepatitis C and/or behavioral health services, especially for those members who have received prior authorization from their previous MCE or through fee-for-service;

- A member's transition into the HIP program from traditional fee-for-service;
- A member's transition between MCEs, particularly during an inpatient stay;
- A member's transition between IHCP programs, particularly when a HIP member becomes pregnant or disabled;
- A member's transition following a medically frail determination;
- Members exiting the HIP program to receive excluded services;
- A member's transition to a new PMP
- A member's transition to private insurance or Marketplace coverage;
- A member's transition to no coverage; and
- A member's transition between HIP benefit plans (i.e. HIP Plus, HIP Basic, and HIP State Plan).

In situations such as a member or PMP disenrollment, the Contractor shall facilitate care coordination with other MCEs or other PMPs. When receiving members from another MCE or fee-for-service, the Contractor shall honor previous authorizations for a minimum of thirty (30) calendar days from the member's date of enrollment with the Contractor. The Contractor shall establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's enrollment in their plan. For purposes of clarification, the date of member enrollment for purposes of the prior authorization time frames set forth in this section begin on the date the Contractor receives the member's fully eligible file from the State.

Additionally, when a member transitions to another source of coverage, the Contractor shall be responsible for providing the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as disease management, case management or care management notes. This process shall be overseen by the Transition Coordination Manager.

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

See Section 6.7 for additional requirements regarding continuity of care for behavioral health services, and Section 3.4 for additional requirements regarding continuity of care for pregnant members. The HIP MCE Policies and Procedures Manual describes the Contractor's continuity and coordination of care responsibilities in more detail.

6.14 Out-of-Network Services

With the exception of certain self-referral services described in Section 6.2, and the requirements to allow continuity of care for pregnant women transferring to the Contractor in their third trimester described in Section 3.4, and members with presumptive eligibility seeking initial care, the Contractor may limit its coverage to services

provided by in-network providers once the Contractor has met the network access standards set forth in Section 8. However, in accordance with 42 CFR 438.206(b)(4), which relates to coverage of out-of-network services, the Contractor shall authorize and pay for out-of-network care if the Contractor is unable to provide necessary covered medical services within sixty (60)-miles of the member's residence by the Contractor's provider network. In addition, upon at least thirty (30) calendar days' advance notice, the State may also require the Contractor to begin providing out-of-network care in the event the Contractor is unable to provide necessary covered medical services within the Contractor's provider network within specified timeliness standards defined by the State.

The Contractor shall authorize these out-of-network services in the timeframes established in Section 9.3.2 and shall adequately cover the services for as long as the Contractor is unable to provide the covered services in-network. The Contractor shall require out-of-network providers to coordinate with the Contractor with respect to payment. Per 42 CFR 438.206(b)(5), the cost to the member for out-of-network services shall be no greater than it would be if the services were furnished in-network.

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

The Contractor shall reimburse any out-of-network provider's claim for authorized services at a negotiated rate or according to administrative code 405 IAC 10-9-4 (b) and State statute IC 12-15-44.5-5.

Contractors shall make nurse practitioner services available to members. Members shall be allowed to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the member's service area within the Contractor's network. If nurse practitioner services are available through the Contractor, the Contractor shall inform the member that nurse practitioner services are available.

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

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

6.14.1 Out-of-Network Provider Reimbursement

The Contractor shall reimburse any out-of-network provider's claim for authorized services provided to HIP members. Notwithstanding the foregoing, out-of-network services provided to HIP members eligible pursuant to Section 3.3.1 and billed by a hospital provider, shall be reimbursable at standard Medicaid rates, rather than the higher HIP Medicare rates. Contractor must reimburse claims for members who chose the MCE during the HPE application process on the admission date.

6.15 Enhanced Services

The State encourages the Contractor to cover programs that enhance the general health and well-being of its HIP members, including programs that address preventive health,

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

In addition, all enhanced services shall comply with the member incentives guidelines set forth in Section 9.2.2 and other relevant state and federal rules regarding inducements All enhanced services offered by the Contractor shall be pre-approved by OMPP prior to initiating such services.

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

- Enhanced transportation arrangements (i.e. transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.);
- Enhanced tobacco treatment dependence services;
- Disease management programs or incentives beyond those required by the State;
- Healthy lifestyles incentives; and
- Group visits with nurse educators and other patients.

6.16 Member Cost-Sharing

Effective July 1, 2010, federal regulations at 42 CFR 447.78 place aggregate limits on cost-sharing and prohibit total member cost-sharing per family—including POWER Account contributions, premiums, co-payments and co-insurance—from exceeding five percent (5%) of the family's income, as determined by the State, in a monthly or quarterly period.

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

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

In monitoring the quarterly five percent (5%) member cost-sharing limit, the Contractor

shall comply with all policies and procedures set forth in this section and the HIP MCE Policies and Procedures Manual.

6.17 Opioid Treatment Program (OTP)

The Contractor shall provide coverage for the daily Opioid Treatment Program (OTP). A daily opioid treatment program includes administration and coverage of methadone, routine drug testing, group therapy, individual therapy, pharmacological management, HIV testing, Hepatitis A, B, and C testing, pregnancy tests, Tuberculosis testing, Syphilis testing, follow-up examinations, case management 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.

Eligible members include:

- Members 18 years and older who have become addicted at least one year prior to admission and are placed in the Opioid Treatment Services (OTS) Level of Care according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.
- Members under 18 years of age and have had two documented unsuccessful attempts at short-term withdrawal management or drug free treatment within a 12-month period.
- All members released from penal institution (within six months of release).
- Pregnant members.
- Previously treated members (up to two years after discharge).

7.0 Member Services

7.1 Marketing and Outreach

Marketing efforts shall be targeted to the general community in the Contractor's entire service area. In accordance with 42 CFR 438.104, and the requirements outlined in Section 7.5, the Contractor shall obtain State approval for all marketing materials at least thirty (30) calendar days prior to distribution. The Contractor cannot conduct, directly or indirectly, door-to-door, telephone, email, texting, or other "cold-call" marketing enrollment practices. Cold-call marketing is defined in 42 CFR 438.104, which addresses marketing activities, as any unsolicited personal contact by the Contractor with a potential Medicaid enrollee.

The Contractor may market by mail, mass media advertising (e.g., radio, television and billboards) and community-oriented marketing directed at potential members. The Contractor shall conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. The Contractor shall provide information to potential eligible individuals who live in medically underserved rural areas of the State. Marketing materials shall comply with the information requirements delineated at 42 CFR 438.10, and should include the requirements and benefits of the

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Contractor's health plans, as well as the Contractor's provider network. Such materials shall be in a manner and format that is easily understood and meet the general communication material requirements discussed in this Section 7.

The Contractor may offer to potential members tokens or gifts of nominal value, as long as the Contractor acts in compliance with all marketing provisions provided for in 42 CFR 438.104, which addresses marketing activities, and other federal and state regulations and guidance regarding inducements in the Medicare and Medicaid programs.

All member marketing and outreach materials shall be submitted to OMPP for approval prior to distribution according to the timeframes set forth in Section 7.5.

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

The Contractor cannot entice a potential member to join its health plan by offering any other type of insurance as a bonus for enrollment, and the Contractor shall ensure that a potential member can make his/her own decision as to whether or not to enroll. Marketing materials and plans shall be designed to reach a distribution of potential members across age and sex categories. 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 OMPP for approval. If approved, the Contractor can make these posters available to the local DFR offices and other enrollment centers for display in an area where application and MCE selection occurs. The local DFR offices and enrollment centers may display these promotional materials at their discretion. The Contractor may display these same promotional materials at community health fairs or other outreach locations. OMPP shall pre-approve all promotional and informational brochures or flyers and all graphics prior to display or distribution.

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

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7.2 Member Enrollment

Indiana Health Coverage Program applicants have an opportunity to select an MCE on their application. MCEs are expected to conduct marketing and outreach efforts to raise awareness of both the program and their product. The Enrollment Broker is available to assist members in choosing an MCE. Applicants who do not select an MCE on their application will be auto- assigned to an MCE according to the State's auto-assignment methodology. The State reserves the right to amend the auto-assignment logic and may incorporate HEDIS or other quality indicators into the auto-assignment logic at a future date. Default auto-assignment will not be available to any MCE who does not successfully complete readiness review

In accordance with 42 CFR 438.10(e), the State shall provide to potential members 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 Contractor service area, benefits covered, cost-sharing and network provider information. The State shall provide information on program 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 shall comply with State requests for information needed to develop informational materials for potential members.

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

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

7.2.1 New Member Materials

Within five (5) calendar days of a new member's full enrollment with the Contractor in accordance with Section 4.6, the Contractor shall send the new member a Welcome Packet based on the State's model enrollee handbook. The Welcome Packet shall include, but not be limited to, a new member letter, explanation of where to find information about the Contractor's provider network, where to locate the member handbook including a summary of items found in the member handbook as described in Section 7.4.1, and the member's ID card. The Contractor shall be responsible for issuing member ID cards to all of its new HIP members. Furthermore, if a member loses their card, the Contractor will be responsible for printing new member ID cards for their members. Refer to the HIP MCE Policies and Procedures Manual for specific information regarding HIP member ID card requirements.

The Welcome Packet shall include information on the HIP member ID card. The

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

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

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

- The POWER Account;
- Member required cost sharing;
- Non-payment penalties;
- POWER Account roll over, including the recommended preventive care services for the member's benefit year;
- General information regarding the importance of timely completion of the comprehensive health assessment for members initially identified as potentially medically frail;
- GTW requirements, eligibility information, and suspension information;
- GTW member communications and assistance planning; and
- GTW qualifying activities.

7.2.2 PMP Selection

The Contractor shall assure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. Following a member's enrollment, the Contractor shall assist the member in choosing a PMP. Unless the member elects otherwise, the member shall be assigned to a PMP within thirty (30) miles of the member's residence.

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

The Contractor shall have written policies and procedures for allowing members to select a new PMP, including PMP auto-assignment, and provide information on

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

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

7.2.3 Health Screening

The Contractor shall conduct a Health Needs Screen (HNS) for new members that enroll in the Contractor's plan. The HNS will be used to identify the member's physical and/or behavioral health care needs, special health care needs, as well as the need for disease management, case management and/or care management services set forth in Section 6.8. The HNS may be conducted in person, by phone, online or by mail. The Contractor shall use the standard health screening tool developed by OMPP, i.e., the Health Needs Screening Tool, but is permitted to supplement the OMPP Health Needs Screening Tool with additional questions developed by the Contractor. Any additions to the OMPP Health Needs Screening Tool shall be approved by OMPP.

The HNS shall be conducted within ninety (90) calendar days of the Contractor's receipt of a new member's fully eligible file from the State. Notwithstanding the foregoing, in accordance with Section 3.3.2, the Contractor shall use best efforts to conduct the HNS of individuals identified as potentially medically frail as soon as practicable prior to the expiration of the member's Verification Period. The Contractor is encouraged to conduct the HNS at the same time it assists the member in making a PMP selection. The Contractor shall also be required to conduct a subsequent health screening or comprehensive health assessment if a member's health care status is determined to have changed since the original screening, such as evidence of overutilization of health care services as identified through such methods as claims review. Non-clinical staff may conduct the HNS. The results of the HNS shall be transferred to OMPP in the form and manner set forth by OMPP.

As part of this contract, the Contractor shall not be required to conduct HNS for members enrolled in the Contractor's plan prior to January 1, 2017 unless a change in the member's health care status indicates the need to conduct a health screening. For purposes of the HNS requirement, new members are defined as members that have not been enrolled in the Contractor's plan in the previous twelve (12) months.

Data from the HNS or NOP form, current medications and self-reported medical conditions will be used to develop stratification levels for members in HIP. While the Contractor may use its own proprietary stratification methodology to determine which members should be referred to specific care coordination services ranging from disease management to complex case management, OMPP shall apply its own stratification methodology which may, in future years, be used to link stratification level to the per member per month capitation rate.

The initial HNS shall be followed by a detailed Comprehensive Health Assessment Tool (CHAT) by a health care professional when a member is identified through the

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HNS as having a special health care need, as set forth in Section 7.2.4, or when there is a need to follow up on problem areas found in the initial HNS. The detailed CHA may include, but is not limited to, discussion with the member, a review of the member's claims history and/or contact with the member's family or health care providers. These interactions shall be documented and shall be available for review by OMPP. If the CHAT is used to affirm a member's medically frail designation, in which case, the Contractor shall report to the State in the form and manner prescribed in Section 3.3.2.

The Contractor shall keep up-to-date records of all members found to have special health care needs, including, but not limited to those formally designated as medically frail, based on the initial screening, including documentation of the follow-up detailed CHAT and contacts with the member, their family or health care providers.

7.2.4 Children with Special Health Care Needs

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

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

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

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

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

- Conducting the initial screening and more detailed health assessment to identify members between 19 and 21 years of age who may have special needs;
- Scoring the initial screening and more detailed health assessment results;
- Distributing findings from the health assessment to the member's PMP, OMPP and other appropriate parties in accordance with state and federal confidentiality regulations;
- Coordinating care through a Special Needs Unit or comparable program services in accordance with the member's care plan;
- Analyzing, tracking and reporting to OMPP the issues related to children with special health care needs, including grievances and appeals data; and
- Participating in clinical studies of special health care needs as directed by the State.

7.2.5 Member Disenrollment from MCE

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

The Contractor shall notify OMPP in the manner outlined in the HIP MCE Policies and Procedures Manual, within thirty (30) calendar days of the date it becomes aware of the death of one of its members, giving the member's full name, address, Social Security Number, member identification number and date of death. The Contractor will have no authority to pursue recovery against the estate of a deceased Medicaid member.

Additional information about the member disenrollment process is provided in Exhibit 8 and the HIP MCE Policies and Procedures Manual.

7.3 Member-Contractor Communications

7.3.1 Member Services Helpline

The Contractor shall maintain a statewide toll-free telephone helpline staffed with trained personnel knowledgeable about the HIP program equipped to handle a variety of member inquiries, including the ability to address member questions, concerns, complaints and requests for PMP changes. The same helpline shall be available to HIP members, so that members may call one number to answer all the family's questions. Member helpline staff shall be equipped to provide customer service to individuals assigned to the Contractor's plan who have not yet made their first POWER Account contribution. Member helpline staff shall be knowledgeable about the GTW program including program explanation, member status, basic GTW questions, and referrals to resources.

The Contractor shall staff the member services helpline to provide sufficient "live voice" access to its members during, at a minimum, a twelve (12)-hour business

day, from 8 a.m. to 8 p.m. Eastern, Monday through Friday. The Contractor shall provide a voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day.

The member helpline may be closed on the following holidays:

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

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

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

The member services helpline shall offer language translation services for members whose primary language is not English and shall offer automated telephone menu options in English and Spanish. A member services messaging option shall be available after business hours in English and Spanish. The Contractor shall provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members.

Member services helpline staff shall be trained in the HIP program to ensure that member questions and concerns are resolved as expeditiously as possible. The Contractor shall have the ability to warm transfer members to outside entities including the Enrollment Broker, the Division of Family Resources (DFR) and provider offices. The Contractor shall maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours. The Contractor shall monitor its member services helpline service and report its telephone service level performance to OMPP in the timeframes and specifications described in the HIP MCE Reporting Manuals.

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

- Access to health care services;
- Identification or explanation of covered services;

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- Special health care needs;
- Procedures for submitting a member grievance or appeal;
- Potential fraud or abuse;
- Changing PMPs;
- POWER Accounts and POWER Account balances;
- HIP POWER Account contributions, including initial fast track prepayments;
- Transfers between HIP benefit plans;
- Incentive programs;
- Disease management services;
- Recommended age and sex appropriate preventive services (HIP only);
- Transfers between HHW and HIP coverage;
- Employer and other third party HIP POWER Account contributions;
- GTW program support;
- Balance billing issues; and
- Health crises, including but not limited to suicidal callers.

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

7.3.2 Electronic Communications

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

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

The Contractor shall maintain the capability to report on e-mail communications received and responded to, such as total volume and response times. The Contractor shall be prepared to provide this information to OMPP upon request.

The Contractor shall collect information on member's preferred mode of receipt of

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

If the member elects to receive electronic communications, electronic communication shall not be used in lieu of any GTW member communications or assistance planning requirements required by the MCE Policy and Procedure manual.

7.4 Member Information, Outreach and Education

The Contractor shall provide the information listed under this section within a reasonable timeframe, following the notification from the State fiscal agent of the member's enrollment in the Contractor. This information shall be included in the member handbook.

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

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

The Contractor shall notify all members of their right to request and obtain information in accordance with 42 CFR 438.10. In addition to providing the specific information required at 42 CFR 438.10(f) upon enrollment in the Welcome Packet as described in Section 7.2.1, the Contractor shall notify members at least once a year of their right to request and obtain this information. Written notice shall be given to each member of any significant change in this information at least thirty (30) days before the intended effective date of the change. Significant change is defined as any change that may impact member accessibility to the Contractor's services and benefits.

The Contractor shall make written information available in English and Spanish and other prevalent non-English languages identified by OMPP, upon OMPP'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. In addition, the Contractor shall identify additional languages that are prevalent among the Contractor's membership. For purposes of this requirement, prevalent language is defined as any language spoken by at least three percent (3%) of the general population in the Contractor's service area. Written information shall be 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

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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 shall inform members that information is available upon request in alternative formats and how to obtain them. OMPP defines alternative formats as braille, large font letters, audiotape, prevalent languages and verbal explanation of written materials. As of May 1, 2020, 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. To the extent possible, written materials shall not exceed a fifth grade reading level.

The Contractor shall provide notification to OMPP, to the Enrollment Broker and to its members of any covered services that the Contractor or any of its sub-contractors or networks do not cover on the basis of moral or religious grounds and guidelines for how and where to obtain those services, in accordance with 42 CFR 438.102, which relates to provider-enrollee communications. This information shall be relayed to the member before and during enrollment and within ninety (90) calendar days after adopting the policy with respect to any particular service. Refer to Section 9.3.3 for additional information.

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

Grievance, appeal and fair hearing procedures and timeframes shall be provided to members in accordance with 42 CFR 438.10(g)(2)(xi), which requires specific information be provided to enrollees. Please see Section 7.9 for further information about grievance, appeal and fair hearing procedures, as well as the kind of information that the Contractor shall provide to members.

The Contractor shall be responsible for developing and maintaining member education programs designed to provide the members with clear, concise and accurate information about the Contractor's program, the Contractor's network and the HIP program. The State encourages the Contractor to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the Contractor to develop community partnerships with these types of organizations, in particular with school based health centers, community mental health centers, WIC clinics, county health departments and prenatal clinics to promote health and wellness within its membership. In the first and third quarter of every Contract year, the Contractor shall identify members who are potentially eligible for the Supplemental Nutritional Assistance Program (SNAP). The Contractor shall use the federal poverty level of 130% to identify potentially eligible members. The Contractor shall conduct an educational outreach campaign to the members identified as potentially eligible. The Contractor does not need to outreach to all potentially eligible members at once, but can conduct outreach on a rolling basis during the quarter identified and the following quarter (e.g., reach out to each potentially eligible member once in the first or second quarter and once again in the third or fourth quarter of every Contract year) . The educational information provided to members shall include information on SNAP benefits, eligibility, and how to enroll. The Contractor shall develop communication strategies that meet the requirements of this section, and provide innovative approaches to ensure member understanding of the HIP program. The

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Contactor shall, at minimum, provide program information to the member through required notices and other communications prescribed by the State.

The Contractor's educational activities and services shall also address the special needs of specific HIP subpopulations (e.g., medically frail, pregnant women, at-risk members, children with special needs) as well as its general membership. The Contractor shall demonstrate how these educational interventions reduce barriers to health care and improve health outcomes for members.

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

7.4.1 Member Handbook

The Contractor shall develop a member handbook for its HIP members. The Contractor may choose to develop a separate handbook for the HIP line of business. The Contractor's member handbook shall be submitted annually for OMPP's review. The member handbook shall include the Contractor's contact information and Internet website address and describe the terms and nature of services offered by the Contractor, including the following information required under 42 CFR 438.10(f), which enumerates certain required information. The member handbook may be offered in an electronic format as long as the Contractor complies with 42 CFR 438.10(c)(6). The HIP MCE Policies and Procedures Manual outlines the member handbook requirements.

The HIP member handbooks shall include the following:

- Contractor's contact information (address, telephone number, TDD number, website address);
- The amount, duration and scope of services and benefits available under the Contract in sufficient details to ensure that participants are informed of the services to which they are entitled, including, but not limited to the differences between the HIP Plus and HIP Basic benefit options;
- The procedures for obtaining benefits, including authorization requirements;
- Contractor's office hours and days, including the availability of a 24-hour Nurse Call Line;
- Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out-of-network providers;
- The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(f), such as what constitutes an emergency;
- The post-stabilization care services rules set forth in 42 CFR 422.113(c);

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- The extent to which, and how, urgent care services are provided;
- Applicable policy on referrals for specialty care and other benefits not provided by the member's PMP, if any;
- HIP pregnancy policies, including, a description of the HIP Maternity program (MAMA);
- HIP cost-sharing policies, including, but not limited to non-payment penalties resulting in lock-out or transfer to HIP Basic, as well as the exceptions to such non- payment penalties, as detailed in Section 4.7.1.2;
- HIP tobacco surcharge for members who use tobacco;
- HIP co-payments for emergency room services, and the ability to receive a waiver by calling the 24-hour Nurse Call Line prior to utilizing a hospital emergency department;
- Information about the availability of pharmacy services and how to access pharmacy services;
- Member rights and protections, as enumerated in 42 CFR 438.100, which relates to enrollee rights. See Section 7.8 for further detail regarding member rights and protections;
- Responsibilities of members;
- Special benefit provisions (for example, co-payments, deductibles, limits or rejections of claims) that may apply to services obtained outside the Contractor's network;
- Procedures for obtaining out-of-network services;
- Standards and expectations to receive preventive health services;
- Policy on referrals to specialty care;
- Procedures for notifying members affected by termination or change in any benefits, services or service delivery sites;
- Procedures for appealing decisions adversely affecting members' coverage, benefits or relationship with the Contractor, including, but not limited to a medically frail determination and tobacco user designation;
- Procedures for changing PMPs;
- Standards and procedures for changing MCEs, and circumstances under which this is possible, including, but not limited to providing contact information and instructions for how to contact the enrollment broker to transfer MCEs due to one of the "for cause" reasons described in 42 CFR 438.56(d)(2)(iv), including, but not limited to, the following:
    - Receiving poor quality of care;

- Failure to provide covered services;
- Failure of the Contractor to comply with established standards of medical care administration;
- Lack of access to providers experienced in dealing with the member's health care needs;
- Significant language or cultural barriers;
- Corrective action levied against the Contractor by the office;
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the Contractor's contract with the State;
- A service is not covered by the Contractor for moral or religious objections, as described in Section 9.3.3;
- Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE;
- A member that was not given the opportunity to select an MCE in open enrollment may change their MCE during the first 60 days of the new benefit period;
- A change in aid category; or
- Other circumstances determined by the State or its designee to constitute poor quality of health care coverage.

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

- HIP members may only change MCEs for cause, unless the change is requested prior to either (i) making their initial POWER account contribution or fast track prepayment or (ii) being enrolled in HIP Basic or HIP State Plan Basic in accordance with Section 4.6, whichever occurs first;
- Members are required to exhaust the MCE's internal grievance and appeals process before requesting an MCE change due to 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 shall provide the Enrollment Broker's contact information and explain that the member must contact the Enrollment Broker with questions about the process. This information shall include how to obtain the Enrollment Broker's standardized form for requesting an MCE change.

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

- Procedures for making complaints and recommending changes in policies and services;

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

    - The right to file grievances and appeals;
    - The requirements and 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.

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

- Information about advance directives;

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

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

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

- Information on how to contact the Enrollment Broker;

- Statement that 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;

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

- Information on the tobacco surcharge; and

- GTW requirements, eligibility, member reporting, pre-suspension activities, State suspensions, and grievances and appeals.

7.4.2 Member Website

The Contractor shall provide and maintain a website for members to access information pertaining to the HIP program and the Contractor's services. The

website shall be in an OMPP-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines. The website shall be live and meet the requirements of this section on the effective date of the Contract. OMPP must pre-approve the Contractor's website information and graphic presentations. The website shall be accurate and current, culturally appropriate, written for understanding at a fifth grade reading level and available in English and Spanish. The Contractor shall inform members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor shall date each web page, change the date with each revision and allow users print access to the information. Such website information shall include, at minimum, the following:

- The Contractor's searchable provider network identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access and other demographic information as described in Section 8.11. The Contractor shall update the on-line provider network information every two (2) weeks, at a minimum;

- The Contractor's contact information for member inquiries, member grievances and appeals;

- The Contractor's member services phone number, TDD number, hours of operation and after-hours access numbers, including the 24-hour Nurse Call Line;

- A member portal with access to electronic Explanation of Benefit (EOB) statements. For HIP members, the member portal shall also include up-to-date POWER Account balance information, including the required annual and monthly contribution amounts and payments made for HIP Plus or HIP State Plan Plus members;

- Information about the cost and quality of health care services, as further described in Section 7.4.5;

- A description of the Contractor's disease management programs and care coordination services

- The member's rights and responsibilities, as enumerated in 42 CFR 438.100, which relates to enrollee rights. Please see Section 7.8 for further details regarding member rights.

- The member handbook information;

- Contractor-distributed literature regarding all health or wellness promotion programs that are offered by the Contractor;

- Contractor's marketing brochures and posters;

- Notification letters to members regarding Contractor decisions to terminate, suspend or reduce previously authorized covered services;

- The Health Insurance Portability and Accountability Act (HIPAA) privacy statement;
- Links to OMPP's website for general HIP information;
- Information on pharmacy locations and preferred drug lists applicable to each program and benefit package;
- List of all prior authorization criteria for prescription drugs, including mental health drugs;
- Information about how HIP State Plan and HIP Plus members may access dental services and how to access the Contractor's dental network;
- A list and brief description of each of the Contractor's member outreach and education materials;
- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report;
- Information on behavioral health covered services and resources;
- A secure portal through which members may complete the health screening questionnaire described in Section 7.2.3;
- Preventive care and wellness information. For HIP, this information shall include the preventive care services that qualify a member for POWER Account roll over;
- Information on the annual open enrollment period from November 1 to December 15th where members may make a new MCE selection for the next calendar year; and
- Gateway to Work requirements, eligibility, member reporting, pre-suspension activities and State suspension, and links to the Gateway to Work website for partner resources and the member portal.

7.4.3 Preventive Care Information

The Contractor is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care standards. For HIP and members under twenty-one (21) years of age, this would include information on EPSDT, well-child services and blood lead screenings. For HIP members, these plans shall include reminders that encourage members to obtain the OMPP-recommended preventive services for their age, gender and pre-existing conditions, including an explanation that preventive services are not subject to the member's deductible and that the member may be able to roll over a portion of the member's POWER Account balance in accordance with Section 5.6 if recommended preventive services are obtained. Further information on education requirements for disease specific conditions and disease management, care management and complex case management communications is provided in Section 6.8.

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7.4.4 HIP Member Education

The requirements of this Section 7.4.4 apply to the Contractor's HIP line of business only.

7.4.4.1 HIP Benefit Plans Education

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

7.4.4.2 Power Account Education

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

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

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

- The opportunity for employers, nonprofits and other third parties to contribute to member POWER Accounts;
- Non-payment policies, including (i) termination from HIP for individuals above 100% FPL or transfer to HIP Basic for individuals at or below 100% FPL if a contribution is not received within sixty (60) calendar days of its due date, as described in Section 4.7; (ii) inability for terminated individuals above 100% FPL to reapply for HIP for six (6) months, as described in Section

4.7; (iii) the exceptions to the policies listed in subsection (i) and (ii) above, as described in Section 4.7.1; (iv) inability for members transferred to HIP Basic to obtain HIP Plus benefits until the member's next eligibility period; (v) HIP debt policies; and (vi) forfeiture of twenty five percent (25%) of remaining POWER Account balance in accordance with Section 4.5;

- Policies regarding how members may report a change in income or family size that may impact their eligibility or benefits;
- POWER Account roll over policies for both HIP Plus and HIP Basic, including information on how members may obtain recommended preventive care; and
- POWER Accounts may not be utilized to pay for HIP Basic copayments or required emergency room copayments.

7.4.4.3 Gateway to Work Education and Information

The Contractor shall educate its members about the GTW program. The Contractor shall establish a variety of methods, to be approved by the State, in which it will provide GTW education to members. GTW education shall emphasize GTW is a community engagement program that seeks to improve HIP members' physical and mental health, overall financial stability, and well-being. Education shall include information about how the program promotes opportunities, resources, and connections for HIP members to gain or improve their employment situation, seek additional training or education, and increase community engagement through volunteer work. GTW education materials shall include, at a minimum, information about:

- GTW eligibility, Referral Status, and exemptions
- GTW qualifying activities
- GTW member portal and member reporting requirements
- GTW assistance planning
- GTW annual compliance reviews, pre-suspension activities, and State suspension

7.4.5 Cost and Quality Information

Making cost and quality information available to members increases transparency and has the potential to reduce costs and improve quality. The Contractor shall make cost and quality information available to members in order to facilitate more responsible use of health care services and inform health care decision-making. Example cost information includes average cost of common services, urgent versus emergent care costs, etc.

For services 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

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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 10.1. Specific services for member verification may be identified by the OMPP PI Unit and may change based upon fraud trends. Processes for verifying services with members shall be included in the Contractor's Program Integrity Plan.

The Contractor shall provide a member portal with access to electronic EOB statements for its HIP members. In addition, the Contractor shall generate and mail EOB statements to, at minimum, HIP members on a monthly basis. For HIP members, the EOB statements shall indicate when services are paid with POWER Account funds. The POWER Account Statement required in Section 5.3 and EOB information may be combined in a single statement for HIP members. The Contractor shall give HIP members an opportunity to receive e-mail alerts about EOB information on the member's secure web portal, in addition to or as an alternative to receiving the information by mail.

Provider quality information shall also be made available to members. The Contractor shall capture quality information about its network providers, and shall make this information available to members. In making the information available to members, the Contractor shall identify any limitations of the data. The Contractor shall also refer members to quality information compiled by credible external entities (e.g., Hospital Compare, Leap Frog Group, etc.).

7.5 Member and Potential Member Communications Review and Approval

All member and potential member communications required in this section or otherwise developed by the Contractor shall be pre-approved by OMPP. The Contractor shall develop and include a Contractor-designated inventory control number on all member marketing, education, training, outreach and other member materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate OMPP'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 OMPP for review and approval at least thirty (30) calendar days prior to expected use and distribution. Substantive changes to member and potential member communications shall also be submitted to OMPP for review and approval at least thirty (30) calendar days prior to use.

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

OMPP shall assess liquidated damages as set forth in Exhibit 4 and impose other authorized remedies for the Contractor's non-compliance in the use or distribution of any non-approved member or potential member communications.

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

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

7.6 Redetermination Assistance

Contractors may assist members in the eligibility redetermination process. Contractors will receive the member's redetermination date on the 834. Permitted assistance includes:

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

In providing assistance during redetermination, Contractors shall be prohibited from the following:

- Discriminate against members, particularly high-cost members;
- Talk to members about changing MCEs (if a member has questions or requests to change MCEs, the Contractor shall refer the member to the Enrollment Broker), members may be educated about the once annual open enrollment period and advised that they are not eligible to change due to redetermination,
- Provide any indication as to whether the member will be eligible (this decision shall be made by DFR);
- Engage in or support fraudulent activity in association with helping the member complete the redetermination process;
- Sign the member's redetermination form; or
- Complete or send redetermination materials to DFR on behalf of the member.

Contractors shall provide redetermination assistance equally across the membership and be able to demonstrate to OMPP that their redetermination-related procedures are applied consistently for each member.

7.7 Member-Provider Communications

The Contractor shall comply with 42 CFR 438.102, which relates to provider-enrollee communications. The Contractor shall not prohibit or otherwise restrict a health care professional, acting within his or her lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding the following:

- the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under the HIP program;
- any information the member needs in order to decide among all relevant treatment options;

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- the risks, benefits, and consequences of treatment or non-treatment; and
- the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

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

7.8 Member Rights

The Contractor shall guarantee the following rights protected under 42 CFR 438.100 to its members:

- The right to receive information in accordance with 42 CFR 438.10, which relates to informational materials;
- 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 the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information; and
- The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

The Contractor shall also comply with other applicable state and federal laws regarding member rights, as set forth in 42 CFR 438.100(d).

The Contractor shall have written policies in place regarding the protected member rights listed above. The Contractor shall have a plan in place to ensure that its staff and network providers take member rights into account when furnishing services to the Contractor's members.

Members shall be free to exercise protected member rights, and the Contractor shall not discriminate against a member that chooses to exercise his or her rights.

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

7.9 Member Grievances and Appeals

The Contractor shall establish written policies and procedures governing the resolution of grievances and appeals. At a minimum, the grievance system shall include a grievance process, an appeal process, expedited review procedures, external review procedures and access to the State's fair hearing system. The Contractor's grievances and appeals system, including the policies for recordkeeping and reporting of grievances and appeals, shall comply with 42 CFR 438, Subpart F, which relates to the Contractor's grievance system, as well as IC 27-13-10 and IC 27- 13-10.1 (if the Contractor is licensed as an HMO) or IC 27-8-28 and IC 27-8-29 (if the Contractor is licensed as an accident and sickness insurer), as described within the HIP MCE Policies and Procedures Manual.

The term *grievance,* as defined in 42 CFR 43 8.400(b), is an expression of dissatisfaction about any matter other than an "action" 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 *action,* as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service excluding the denial of a claim that does not meet the definition of a clean claim. A "clean claim" is one in which all information required for processing the claim is present;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of a Contractor to act within the required timeframes; or
- 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).

The Contractor shall notify the requesting provider, and give the member written notice, of any decision considered an "action" taken by the Contractor, including, but not limited to any decision by the Contractor (i) to deny a service authorization request, (ii) to authorize a service in an amount, duration or scope that is less than requested, or (iii) that is adverse to the member regarding a medically frail designation. The notice shall meet the requirements of 42 CFR 438.404, "Notice of Action." See Section 9.3.2, Authorization of Services and Notices of Action for additional information.

7.9.1 Contractor Grievance and Appeals Policies

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

- The Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member, in accordance with 42 CFR 438.102,

which relates to provider-enrollee communications. A provider, acting on behalf of the member and with the member's written consent, may file an appeal;

- The Contractor shall not take punitive action against a provider who requests or supports an expedited appeal on behalf of a member;
- Throughout the appeals process, the Contractor shall consider the member, representative or estate representative of a deceased member as parties to the appeal;
- In accordance with 42 CFR 438.406, provide the member and member representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process;
- Allow the member and member representative to present evidence, and allegations of fact or law, in person as well as in writing;
- Upon determination of the appeal, ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The Contractor's appeal decision notice shall describe the actions taken, the reasons for the action, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e), which enumerates required content of a notice of resolution;
- The Contractor shall notify members of the disposition of grievances and appeals pursuant to IC 27-13-10-7 (if the Contractor is licensed as an HMO) or IC 27-8-28-16 (if the Contractor is licensed as an accident and sickness insurer);
- The Contractor shall provide members any reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;
- The Contractor shall ensure that the individual rendering the decision on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; and (iii) any grievance or appeal involving clinical issues.
- The Contractor shall ensure that the individual rendering the decision on appeals related to the Contractor's medically frail determination are licensed physicians.

7.9.2 Grievance Processing Requirements

In accordance with 42 CFR 438.402, members shall be allowed to file grievances orally or in writing. Members may file a grievance regarding any matter other than

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those described in the definition of an action as described in this Section 7.9. Grievances may be filed within sixty (60) calendar days of the occurrence of the matter that is the subject of the grievance.

The Contractor shall acknowledge receipt of each grievance within three (3) business days. The Contractor shall make a decision on non-expedited grievances as expeditiously as possible, but not more than thirty (30) calendar days following receipt of the grievance. This timeframe may be extended up to fourteen (14) calendar days if resolution of the matter requires additional time. If the timeframe is extended, for any extension not requested by the member, the Contractor shall 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 shall be resolved within forty-eight (48) hours of receipt. If the Contractor denies a request for an expedited review, the Contractor shall transfer the grievance to the standard grievance timeframe. Further, the Contractor shall make a reasonable effort, including a phone call to the member, to provide the member with prompt oral notification of the denial for an expedited review, and shall follow up with a written notice within two (2) calendar days.

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

7.9.3 Appeals Processing Requirements

Members, or providers acting on the member's behalf, shall have sixty (60) calendar days from the date of action notice within which to file an appeal. 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. As of March 1, 2020, oral requests no longer need to be followed by a written request.

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

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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 shall 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), which allows extensions under certain conditions. In addition to the required written decision notice, the Contractor shall make reasonable efforts to provide the member with prompt oral notice of the disposition of the appeal, including a phone call to the member.

In accordance with 42 CFR 438.410, if the Contractor denies the request for an expedited resolution of a member's appeal, the Contractor shall transfer the appeal to the standard thirty (30) calendar day timeframe and give the member written notice of the denial within two (2) days of the expedited appeal request. The Contractor shall also make a reasonable attempt to give the member prompt oral notice.

In accordance with 42 CFR 438.408, written notice of appeal disposition shall be provided to the member. Notice shall be provided within five (5) business days of resolution. For notice of an expedited resolution, the Contractor shall also make reasonable efforts, including a phone call to the member, to provide oral notice. The written notice of the resolution shall include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice shall include the right to request a State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. This shall also include notice that the member may be held liable for the cost of those benefits if the State hearing upholds the Contractor's action as set forth in Section 7.9.6.

For member appeals related to adverse decisions related to medically frail determinations made in accordance with Section 3.3.2, the Contractor shall provide notice to the State within one (1) business day of receipt of the appeal.

If members were mistakenly identified as tobacco users, the member can appeal tobacco use designations through the Contractor. Tobacco use designation is not an eligibility factor; therefore, it is not directly appealable to FSSA. The Contractor shall provide notice to the State via the *Core*MMIS system within one (1) business day of receipt of the appeal.

Upon resolution of the member appeal, the Contractor shall notify the State within one (1) business day of the resolution of the appeal and the date the appeal was resolved.

7.9.4 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. 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

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fair hearing.

Within thirty-three (33) 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.

7.9.5 State Fair Hearing Process

In accordance with 42 CFR 438.408, the State maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions to the State. Appeal procedures for applicants and recipients of Medicaid are found at 405 IAC 1.1. The State fair hearing procedures include the requirements described in this Section, 7.9.5.

Members shall first exhaust the Contractor's grievance and appeals process. The member may request an OMPP fair hearing within one hundred and twenty (120) calendar days from the date of the Contractor's decision.

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. The Contractor shall respond to all requests for documentation required for the FSSA fair hearing within the timeframe identified in the request. In addition, if requested by OMPP at least five (5) business days in advance, the Contractor shall send a representative to the FSSA fair hearing to represent the State. Contractor will be subject to the contract compliance remedies set forth in Exhibit 4 for failing to either (i) provide a timely and satisfactory response to documentation required for an appeal or (ii) to represent the State at the FSSA fair hearing upon adequate notice. Adequate notice, at a minimum, requires notice of hearing mailed by the Indiana Office of Administrative Law Proceedings, or in the alternative, a request sent directly to the Compliance Officer by the Office of Medicaid Policy and Planning.

If dissatisfied with the outcome of the State fair hearing, the member may request an agency review within ten (10) days of receipt of the administrative law judge's decision. Pursuant to 405 IAC 1.1-3-1, if the member is not satisfied with the final action after agency review, the member may file a petition for judicial review in accordance with IC 4-21.5-5. The MCE may request an agency review of a decision made by an administrative law judge, at the Contractor's discretion.

The Contractor shall include the FSSA fair hearing process as part of the written internal process for resolution of appeals and shall describe the fair hearing process in the member handbook. All notices of actions with appeal rights and notices of final action by the Contractor where the next course of action is a State Fair Hearing shall have the following language included:

"This is an administrative action by the State of Indiana. If you disagree with this decision, you can appeal it. Appeals are handled by the State of Indiana Office of Administrative Law Proceedings. You may mail your request for a state fair hearing to the State of Indiana Office of Administrative Law Proceedings at:

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

7.9.6 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 shall 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 shall be continued until one of the following occurs:

- The member withdraws the request;
- 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 services has been met.

If the final resolution of the appeal is adverse to the member, that is, it upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements to maintain benefits in accordance with 42 CFR 431.230 and 42 CFR438.420. The Contractor shall notify the member in advance that costs may be recovered. The Contractor may arrange for the member to pay back any such amounts owed in monthly installments, not to exceed four months.

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

7.9.7 Member Notice of Grievance, Appeal and Fair Hearing Procedures

The Contractor shall provide specific information regarding member grievance,

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appeal and State fair hearing procedures and timeframes to members, as well as providers and subcontractors at the time they enter a contract with the Contractor. This information shall be included in the Member Handbook as described in Section 7.4.1. The information provided shall be approved by OMPP in accordance with Section 7.5, and, as required under 42 CFR 438.10(g)(1), include the following:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the member can use to file a grievance or appeal by phone;
- The fact that, if requested by the member and under certain circumstances: 1) benefits will continue if the member files an appeal or requests a FSSA fair hearing within the specified timeframes; and 2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member;
- The right to request an External Review by an Independent Review Organization of decisions listed in 7.9.4; and
- For a FSSA fair hearing:
    - The right to a hearing;
    - The method for obtaining a hearing; and
    - The rules that govern representation at the hearing.

7.9.8 Recordkeeping Requirements of Grievances and Appeals

For purposes of quality review, the Contractor shall accurately maintain records for grievances and appeals that contain, at minimum, the following information:

- A general description of the reason for the appeal or grievance;
- The date the appeal or grievance was received;
- The date the appeal or grievance was reviewed;
- The resolution of the appeal or grievance;
- The date of the resolution of the appeal or grievance; and
- The name and MID number of the member for whom the appeal or grievance was filed.

The Contractor shall provide such record(s) of grievances and appeals upon request by OMPP.

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

7.10 Oral Interpretation Services

In accordance with 42 CFR 438.10(d), the Contractor shall arrange for oral interpretation services to its members free of charge for services it provides, including, but not limited to the member services helpline described in Section 7.3.1 and 24-Hour Nurse Call Line. The Contractor shall notify its members of the availability of these services and how to obtain them.

The requirement to provide oral interpretation applies to all non-English languages, and is not limited to prevalent languages discussed in Section 7.4. Oral interpretation services shall include sign language interpretation services for the deaf.

Additionally, the Contractor shall ensure that its provider network arranges for oral interpretation services to members seeking healthcare-related services in a provider's service location. This includes ensuring that providers who have twenty-four (24) hour access to healthcare-related services in their service locations or via telephone (e.g., hospital emergency departments, PMPs) shall provide members with twenty-four (24) hour oral interpreter services, either through interpreters or telephone services. For example, the Contractor shall ensure that network providers provide TDD services for hearing impaired members, oral interpreters, and signers.

7.11 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 care in a culturally competent manner. The Contractor shall incorporate the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS) into the provision of health care services for its members. The CLAS standards are available at https://www.thinkculturalhealth.hhs.gov/clas/standards.

7.12 Advance Directives

The Contractor shall comply with the requirements of 42 CFR 422.128, which relates to advance directives, for maintaining written policies and procedures for advance directives. The Contractor shall maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the Contractor's health plan. Specifically, each Contractor shall maintain written policies and procedures that meet requirements for advance directives in Subpart I of 42 CFR 489. Advance directives are defined in 42 CFR 489.100 as "a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Written policies shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. Such statement must clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians, identify the state legal authority permitting such objection and describe the range of medical conditions or procedures affected by the conscience objection.

Written information on the Contractor's advance directive policies, including a description of applicable state law, shall be provided to members in accordance with 42 CFR

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438.10(g)(2) and 42 CFR 438.10(d), which together require written policies around advance directives. Written information shall include their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Written information shall reflect changes in state law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change.

This information shall be provided at the time of initial enrollment. If the member is incapacitated at the time of initial enrollment and is unable to receive information or articulate whether or not he or she has executed an advance directive, the information may be given to the member's family or surrogate. Once the member is no longer incapacitated or unable to receive such information, the Contractor shall ensure the information is given to the individual directly at the appropriate time. Members shall also be informed that complaints concerning noncompliance with the advance directive requirements may be filed with the State. See 42 CFR 422.128 for further information regarding these requirements.

8.0 Provider Network Requirements

The Contractor shall develop and maintain a provider network in compliance with the terms of this section. The Contractor shall ensure that its provider network is supported by written provider agreements, is available and geographically accessible and provides adequate numbers of facilities, physicians, pharmacies, ancillary providers, service locations and personnel for the provision of high- quality covered services for its members, in accordance with 42 CFR 438.206, which relates to availability of services. The Contractor shall also ensure that all of its contracted providers can respond to the cultural, racial and linguistic needs of its member populations. The network shall be able to handle the unique needs of its members, particularly those with special health care needs. The Contractor will be required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner.

The Contractor shall ensure all network providers who, in accordance with IHCP policy, are provider types eligible and required to enroll as an IHCP provider, are enrolled IHCP providers. In some cases, members may receive out-of-network services. In order to receive reimbursement from the Contractor, out-of- network providers shall be IHCP providers. The Contractor shall encourage out-of-network providers to enroll in the IHCP, particularly emergency services providers, as well as providers based in non-traditional urgent health care settings such as retail clinics. An out-of-network provider shall be enrolled in the IHCP in order to receive payment from the Contractor.

8.1 Network Development

OMPP requires the Contractor to develop and maintain a comprehensive network to provide services to its HIP members. The network shall include providers serving special needs populations. For its HIP population, the provider network shall not be any more restrictive for HIP Basic members than for HIP Plus members.

The Contractor shall develop a comprehensive network prior to the effective date of the Contract. The Contractor shall be required during the readiness review process to demonstrate network adequacy through the submission of Geo Access reports in the manner and timeframe required by OMPP. 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. OMPP reserves the right to delay initial member enrollment in the Contractor's plan if the Contractor fails to demonstrate a complete and comprehensive network.

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With approval from OMPP, 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 6.2. The Contractor shall provide ninety (90) calendar day advance notice to OMPP of changes to the network that may affect access, availability and network composition. OMPP shall regularly and routinely monitor network access, availability and adequacy. OMPP shall impose remedies, as set forth in Exhibit 4, or require the Contractor to maintain an open network, if the Contractor fails to meet the network composition requirements.

In accordance with 42 CFR 438.206, the Contractor shall maintain and monitor the provider network. The Contractor shall establish written agreements with all network providers as further described in Section 8.4. In establishing and maintaining the network, the Contractor shall consider the following elements:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of the Contractor's and HIP members;
- The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;
- The numbers of network providers who are not accepting new members; 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.

OMPP shall assess liquidated damages as set forth in Exhibit 4 and shall impose other authorized remedies, such as requiring the Contractor to maintain an open network, for Contractor's non- compliance with the network development and network composition requirements.

The Contractor shall contract its specialist and ancillary provider network prior to receiving enrollment. OMPP shall have the right to implement corrective actions and shall assess liquidated damages as described in Exhibit 4 if the Contractor fails to meet and maintain the specialist and ancillary provider network access standards. OMPP's corrective actions may include, but are not limited to, withholding or suspending new member enrollment from the Contractor until the Contractor's specialist and ancillary provider network is in place. OMPP shall monitor the Contractor's specialist and ancillary provider network to confirm the Contractor is maintaining the required level of access to specialty care. OMPP shall have the right to increase the number or types of required specialty providers at any time.

8.2 Network Composition Requirements

In compliance with 42 CFR 438.207, which provides assurances of adequate capacity and services, the Contractor shall:

- Serve the expected enrollment;
- Offer an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled; and

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- 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 OMPP. Once the Contractor demonstrates compliance with OMPP's access standards, the Contractor shall submit network access reports on an annual 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). The Contractor shall comply with the policies and procedures for network access reports set forth in HIP MCE Reporting Manuals. OMPP shall have the right to expand or revise the network requirements, as it deems appropriate.

In accordance with 42 CFR 438.12, the Contractor shall not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This does not require the Contractor to contract with providers beyond the number necessary to serve the members' needs. The Contractor is not precluded from establishing any measure designed to maintain quality and control costs consistent with the Contractor's responsibilities.

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

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

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

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

8.2.1 Acute Care Hospital Facilities

The Contractor shall provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. The transport distance to a hospital from the member's home shall be the usual and customary, not to exceed thirty (30) miles in urban areas and sixty (60) miles in rural areas. Exceptions shall be justified and documented to the State on the basis of community standards for accessing care. Inpatient services are covered when such services are prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

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8.2.2 Primary Medical Provider (PMP) Requirements

Providers may contract as a PMP with one or multiple MCEs. A PMP may also participate as a specialist in another MCE. The PMP may maintain a patient base of members (e.g., commercial, traditional Medicaid, HIP, Hoosier Healthwise or Hoosier Care Connect members. The Contractor shall not prevent the PMP from contracting with other MCEs.

The Contractor shall demonstrate compliance with 42 CFR 438.208. Specifically, the Contractor shall ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. PMPs must coordinate each member's physical and behavioral health care and make any referrals necessary. The Contractor shall ensure access to PMPs within at least thirty (30) miles of the member's residence. Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians, gynecologists and endocrinologists (if primarily engaged in internal medicine).

The Contractor shall assess the PMP's HIP practice when assessing the PMP's capacity to serve the Contractor's members.

The Contractor shall have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services twenty four (24)-hours-a day, seven (7)-days-a-week and that PMPs have a mechanism in place to offer members direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number twenty four (24)-hours-a-day, seven (7)-days-a-week. Each PMP shall be available to see members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations. The Contractor shall also assess the PMP's and HIP practice to ensure that the PMP's and HIP population is receiving accessible services on an equal basis with the PMP's and HIP population.

The Contractor shall ensure that the PMP provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The Contractor shall ensure that members have telephone access to their PMP (or appropriate designate such as a covering physician) in English and Spanish twenty four (24)-hours-a-day, seven (7)-days-a-week.

The Contractor shall ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the IHCP Provider Manual. The Contractor shall monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

8.2.3 Specialist and Ancillary Provider Network Requirements

In addition to maintaining a network of PMPs, the Contractor shall provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers.

As with PMPs, specialist and ancillary providers shall not be limited to serve in only one MCE network. In addition, physicians contracted as a PMP with one Contractor may contract as a specialist with other MCEs.

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The Contractor shall ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the IHCP Provider Manual. OMPP 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.

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

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

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

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

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county; and

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

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

The Contractor shall contract with the Indiana Hemophilia and Thrombosis Center or a similar OMPP-approved, federally recognized hemophilia treatment center. This requirement is based on the findings of the Centers for Disease Control and Prevention (CDC) which illustrate that persons affected by a bleeding disorder receiving treatment from a federally recognized treatment center require fewer hospitalizations, experience less bleeding episodes and experience a forty percent (40%) reduction in morbidity and mortality.

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

8.2.4 Pharmacy Services

The Contractor shall establish a network of pharmacies. The Contractor or its Pharmacy Benefits Manager (PBM) shall provide at least two (2) pharmacy providers within thirty (30) miles or thirty (30) minutes from a member's residence in each county, as well as at least two (2) durable medical equipment providers in each county or contiguous county.

8.2.5 Non-psychiatrist Behavioral Health Providers

In addition to the access requirements for psychiatrists as described in Section 8.2.3, the Contractor shall establish a network of behavioral health providers, addressing both mental health and addiction, as set forth in this Section 8.2.5.

The Contractor is encouraged to contract with all Division of Mental Health and Addiction (DMHA) certified Community Mental Health Centers (CMHCs). If all CMHCs are not included in the provider network, the Contractor shall demonstrate that this does not prevent coordination of care with MRO and 1915(i) State Plan services as required in Sections 6.11.1 and 6.11.2. Further, as described in Section 6.7.4, the Contractor shall, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs, and shall provide physical health and other medical information to the appropriate CMHC for every member.

The Division of Mental Health and Addiction (DMHA) conducts regular annual Consumer Service Reviews to evaluate the quality of care provided in CMHCs. In addition to the regular oversight that the Contractor provides for contracted CMHCs, the Contractors shall utilize the results of DMHA's review to inform contracting decisions, to monitor contracted CMHCs and to develop improvement plans with contracted CMHCs.

In urban areas, the Contractor shall provide at least one (1) behavioral health

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provider within thirty (30) minutes or thirty (30) miles from the member's home. In rural areas, the Contractor shall provide at least one (1) behavioral health provider within forty-five (45) minutes or forty-five (45) miles from the member's home. The availability of professionals will vary, but access problems may be especially acute in rural areas. The Contractor shall provide assertive outreach to members in rural areas where behavioral health services may be less available than in more urban areas. The Contractor also shall monitor utilization in rural and urban areas to assure equality of service access and availability.

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

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

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

8.2.6 Inpatient Psychiatric Facilities

The Contractor shall provide a sufficient number and geographic distribution of inpatient psychiatric facilities to serve the expected enrollment. The transport distance to an inpatient psychiatric facility from the member's home shall be the usual and customary, not to exceed sixty (60) miles. Exceptions shall be justified and documented to the State on the basis of community standards for accessing care.

8.2.7 Dental Providers

The Contractor shall ensure the availability of a dentist practicing in general or family dentistry within thirty (30) miles of the member's residence. Specialty dentists such as orthodontists and dental surgeons shall be available within sixty (60) miles of the member's residence.

8.2.8 Physician Extenders

Physician extenders are health care professionals who are licensed to practice medicine under the supervision of a physician. Physician extenders can perform some of the services that physicians provide, such as physical exams, preventive health care and education. Some can also assist in surgery and write prescriptions.

Appropriate use of physician extenders can have a positive influence on cost, quality and access. Physician extenders can perform routine or straightforward services at a lower cost than a physician, allowing physicians to focus on more complicated patient problems. Physician extenders also allow patients to be seen promptly for preventive visits or less complicated health problems, which improves access to care and may allow more Medicaid patients to be seen.

According to Indiana law, the following physician extenders are licensed to provide care in Indiana:

- Advanced practice 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;
- Offering financial or non-financial incentives to providers who increase their use of physician extenders, provided any financial incentives shall be positive, not punitive; and
- Collaborating with physician-extender training programs in Indiana. Collaboration could include providing internships or practicum for physician extenders, expanding the number of training slots for physician extenders, etc.

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 shall inform the member that nurse practitioner services are available.

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The Contractor shall have the capability to add certain physician extenders to their networks to be credentialed and contracted as primary care providers should OMPP authorize said physician extenders to participate as primary care providers moving forward.

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

Since Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are essential safety net providers, OMPP strongly encourages the Contractor to contract with FQHCs and RHCs that are willing to contract with the Contractor and meet all of the Contractor's requirements regarding the ability of these providers to provide quality services. The Contractor shall reimburse FQHCs and RHCs for services at no less than the level and amount of payment that the Contractor would make to a non-FQHC or non-RHC provider for the same services. In HIP, Contractors shall make covered services provided by FQHCs and RHCs available to members out-of-network if an FQHC or RHC is not available in the member's service area within the Contractor's network. In accordance with section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), the Contractor shall pay any out-of-network Indian healthcare provider (see Section 8.2.10) that is a FQHC for covered services provided to an American Indian/ Alaska Native member at a rate equal to the amount of payment that the Contractor would pay to an in-network FQHC that is not an Indian health care provider for the same services.

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

OMPP requires the Contractor to identify any performance incentives it offers to the FQHC or RHC. OMPP shall review and must approve any performance incentives. The Contractor shall report all such FQHC and RHC incentives which accrue during the Contract period related to the cost of providing FQHC-covered or RHC-covered services to its members along with any fee-for-service and/or capitation payments in the determination of the amount of direct reimbursement paid by the Contractor to the FQHC or RHC. If the incentives vary between the Contractor's and HIP lines of business, the Contractor shall so specify in its reporting to OMPP.

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

Annually, OMPP requires the Contractor to provide the Contractor's utilization and reimbursement data for each FQHC and RHC in each month of the reporting period. A separate report shall be provided for the Contractor's HIP lines of business. The report shall be completed in the form and manner set forth in HIP MCE Reporting Manuals. For HIP, the data shall be submitted on a paid claims basis.

The submitted FQHC and RHC data shall be accurate and complete. The Contractor shall pull the data by NPI or LPI, rather than other means, such as a Federal Tax ID number. The Contractor shall establish a process for validating the completeness and accuracy of the data, and a description of this process shall be

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

The Contractor shall work with each FQHC and RHC in assisting OMPP and/or its designee in the resolution of disputes concerning year-end reconciliations between the federally required interim payments (made by OMPP to each FQHC and RHC on the basis of provider reported encounter activity) and the final accounting that is based on the actual encounter data provided by the Contractor.

8.2.10 Indian Healthcare Providers

An Indian health care provider is defined as the Indian Health Service (IHS) or an Indian tribe, tribal organization or urban Indian organization (often referred to as I/T/U).

Section 5006 of ARRA provides certain protections for Indian health care providers in Medicaid and CHIP. As outlined in section 5006(d) of ARRA, the Contractor shall:

- Permit any American Indian/ Alaska Native (AI/AN) 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, to choose that Indian healthcare provider as his or her PMP, as long as that Indian healthcare provider has the capacity to provide the services.

- Demonstrate that there are sufficient Indian healthcare providers in the Contractor's network to ensure timely access to services available under the Contract for AI/AN 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 and the Contractor will be held to these standards.

- Reimburse Indian healthcare providers, whether in- or out-of-network, for covered services provided to AI/AN members who are eligible to receive services from such providers in accordance with the requirements set out in Section 1932(h) of the Social Security Act, 42 U.S.C. 1396u-2(h). The rate of payment shall be set at the Encounter Rate established by the IHS on an annual basis and published in the Federal Register.

- Make prompt payment to all in-network Indian healthcare providers as set forth in Section 11.4.3.

- Not reduce payments to Indian healthcare providers, or other providers of contract health services (CHS) under referral by an Indian healthcare provider, for covered services provided to an AI/AN member by the amount of a co-payment or other cost-sharing that would be due from the AI/AN

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member if not otherwise prohibited under Section 5006(a) of ARRA.

Section 5006(d) requires that the State provide a supplemental payment to non-FQHC Indian healthcare providers for covered services provided to AI/AN 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. To the extent OMPP 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 30 days of the request.

8.2.11 County Health Departments

OMPP 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.

8.2.12 Urgent Care Clinics

The Contractor shall affiliate or contract with urgent care clinics. In addition, the State strongly encourages the Contractor to affiliate or contract with non-traditional urgent care clinics, including retail clinics. The State will continue to monitor the Contractor's access to primary and urgent care during readiness review and throughout the Contract term.

8.2.13 Dialysis Treatment Center

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

8.2.14 OB/GYNs

The Contactor shall establish a network of OB/GYNs for women's healthcare and maternity needs. The Contractor shall ensure the availability of at least two OB/GYNs practicing within sixty (60) miles of the member's residence. OMPP shall reserve the right to change this requirement at any time in accordance with Section 2.11.

8.3 Provider Enrollment and Disenrollment

The Contractor shall be responsible for meeting all provider screening and enrollment requirements described in 42 CFR 455 Subpart E. The Contractor is prohibited from contracting with providers who have been or have had owners or operators (i.e., those with a controlling interest) excluded from the Federal Government or by the State's Medicaid program for fraud or abuse. The Contractor, as well as its subcontractors and providers, whether contract or non- contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any services provided by excluded individuals shall be refunded to and/or obtained by the State and/or the Contractor as prescribed in section 10.4 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

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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. OMPP 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 Program Integrity Unit 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. Contractor will provide training to call center care coordination and 24 hour nurse call line staff on locations and hours of urgent care clinics in the plan’s network. The HIP MCE Policies and Procedures Manual provides detailed information on PMP and provider enrollment and disenrollment procedures.

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

The Contractor shall report PMP disenrollments to the State fiscal agent’s Provider Enrollment unit by mail, fax, e-mail or Portal. The Contractor shall first notify the State fiscal agent of the intent to disenroll a PMP within five (5) business days of the receipt/issuance of the PMP’s disenrollment. The fiscal agent shall receive enrollment/disenrollment requests at least five (5) business days prior to the 24th day of the month before the date the Contractor desires the enrollment or disenrollment to become effective. As noted above, the OMPP PI Unit 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. OMPP shall have the right to take corrective actions if the Contractor does not notify the State fiscal agent in a timely manner.

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

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

In accordance with 42 CFR 438.10(f), the Contractor shall make a good faith effort to provide written notice of a provider’s disenrollment 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 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. If a PMP disenrolls from the HIP program, but remains an IHCP provider, the Contractor shall assure that the PMP provides continuation

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of care for and/or HIP members for a minimum of thirty (30) calendar days or until the member's link to another PMP becomes effective.

8.4 Provider Agreements

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

To allow sufficient processing time for the enrollment of the PMP and ensure an effective date of January 1, 2017, the Contractor shall submit the completed PMP enrollment request to the State fiscal agent through the Web Interchange-Provider Healthcare Portal by December 1, 2016.

The Contractor shall include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor shall identify and incorporate the applicable terms of its Contract with the State and any incorporated documents. Under the terms of the provider services agreement, the provider shall agree that the applicable terms and conditions set out in the Contract, any incorporated documents, and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members. The requirement set forth in Section 2.7 that subcontractors indemnify and hold harmless the State of Indiana do not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

In addition to the applicable requirements for subcontracts in Section 2.7, the provider agreements shall 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 ninety (90) calendar days or less from the date of service. The Contractor shall waive the timely filing requirement in the case of claims for members with retroactive coverage.
- Require each provider to utilize the Indiana Health Coverage Program Prior Authorization Request Form available on the Indiana Medicaid website for submission of prior authorization requests to the Contractor.
- Include a termination clause stipulating that the Contractor shall terminate its contractual relationship with the provider as soon as the Contractor has knowledge that the provider's license or IHCP provider agreement has terminated.
- Terminate the provider's agreement to serve the Contractor's HIP members at the end of the Contract with the State.
- Monitor providers and apply corrective actions for those who are out of compliance with FSSA's or the Contractor's standards.

- Obligate the terminating provider to submit all encounter claims for services rendered to the Contractor's members while serving as the Contractor's network provider and provide or reference the Contractor's technical specifications for the submission of such encounter data.

- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors.

- Provide the PMP with the option to terminate the agreement without cause with advance notice to the Contractor. Said advance notice shall not have to be more that ninety (90) calendar days.

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

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

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

- Require each provider to agree to use best commercial efforts to collect required copayments for services rendered to HIP Basic and HIP State Plan Basic members.

The Contractor shall have written policies and procedures for registering and responding to claims disputes for out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6-1.

8.5 Provider Credentialing

The Contractor shall have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current state licensure and enrollment in the IHCP. The Contractor's credentialing and re- credentialing process for all contracted providers shall meet the National Committee for Quality Assurance (NCQA) guidelines. The same provider credentialing standards shall apply across all Indiana Medicaid programs.

The Contractor shall use OMPP's standard provider credentialing form during the credentialing process. The Contractor shall ensure that providers agree to meet all of FSSA's and the Contractor's standards for credentialing PMPs and specialists, and maintain IHCP manual standards, including:

- Compliance with state record keeping requirements;

- FSSA's access and availability standards; and

- Other quality improvement program standards.

As provided in 42 CFR 438.214(c), which prevents discrimination in provider selection, the

Contractor's provider credentialing and selection policies shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor shall not employ or contract with providers that have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act. The Contractor shall notify OMPP, in the manner prescribed by the State, of any credentialing applications that are denied due to program integrity related reasons.

The Contractor shall process all credentialing applications within thirty (30) calendar days of receipt of a complete application. If the Contractor delegates credentialing functions to a delegated credentialing agency, the Contractor shall ensure all credentialed providers are loaded into the Contractor's provider files and claims system within fifteen (15) calendar days of receipt from the delegated entity.

The contractors credentialing and recredentialing process, policies and procedures must be demonstrated in readiness review.

The State intends to implement a centralized model for provider enrollment and credentialing. Upon implementation the Contractor shall accept the FSSA enrollment and credentialing determinations as final. The Contractor shall not require providers to submit supplemental information for purposes of conducting an additional credentialing process. Contractor may not add credentialing requirements to the contracting process, or delay contracting with a provider consistent with IC 12-15-11-9(b). The Contractor shall continue to retain final decision making responsibilities with respect to provider contracts and network design, subject to other requirements of this Contract including but not limited to network adequacy. The Contractor shall comply with all rules, regulations, and policies established.

8.6 Medical Records

The Contractor shall assure that its records and those of its participating providers document all medical services that the member receives in accordance with state and federal law. In accordance with 405 IAC 1-5-1, the provider's medical record shall include, at a minimum:

- The identity of the individual to whom service was rendered;
- The identity of the provider rendering the service;
- The identity and position of the provider employee rendering the service, if applicable;
- The date on which the service was rendered;
- The diagnosis of the medical condition of the individual to whom service was rendered;
- A detailed statement describing services rendered;
- The location at which services were rendered;
- Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs; and

- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment, must be attached to the prior authorization request and available for audit purposes.

The medical records should include details such as prescriptions for medications; inpatient discharge summaries; patient histories (including immunizations) and physicals; a list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs; and a record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and x-ray tests and findings.

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

The Contractor's providers shall provide a copy of a member's medical record upon reasonable request by the member at no charge, and the provider shall facilitate the transfer of the member's medical record to another provider at the member's request.

Confidentiality of, and access to, medical records shall be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal requirements, including, but not limited to, 42 CFR Part 2 specific to confidentiality of alcohol and drug abuse records.

The Contractor's providers shall permit the Contractor and representatives of OMPP 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 1-5-2. The failure of Contractor and/or its participating providers to keep and maintain detailed and accurate medical records as required in this section may result in Contractor and/or its participating providers repaying FSSA for amounts paid corresponding to services rendered for which accurate and detailed medical records are not timely provided.

Records must be provided by Contractor and/or its participating providers upon request within the timeframe identified in the request. FSSA in its sole discretion may authorize additional time for responding to medical records requests made by Contractor or FSSA. The failure of Contractor and/or its participating providers to timely submit records may result in the assessment of an overpayment and/or other non-compliance remedies identified in Exhibit 4. FSSA encourages Contractors to use technology, including the participation in health information exchanges, where appropriate to transmit and store medical record data. See Section 11.8 for more information regarding electronic health records and data sharing requirements.

8.7 Provider Education and Outreach

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

The contractor shall provide a provider relations plan to include frequency of visits and outcomes from concerns identified, program education, claim issues,

etc.

The Contractor shall educate its contracted providers, including behavioral health providers, regarding provider requirements and responsibilities, the Contractor's prior authorization policies and procedures, clinical protocols, member's rights and responsibilities, claims submission process, claims dispute resolution process, program integrity, identifying potential fraud and abuse, pay-for-performance programs and any other information relevant to improving the services provided to the HIP members.

8.7.1 Provider Communications Review and Approval

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

The Contractor shall submit all provider communication materials designed for distribution to, or use by, contracted providers to OMPP for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor shall also submit any material changes to previously approved provider communication materials to OMPP for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor shall receive approval from OMPP prior to distribution or use of materials. OMPP's decision regarding any communication materials is final. The Contractor shall include the State program logo(s) in their provider communication materials upon OMPP request.

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

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

Any provider communications by a subcontractor to IHCP providers regarding the HIP program must comply with the provisions in the section, just as the contractor is required.

8.7.2 Provider Policy and Procedures Manual

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

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minimum, the following information, separately stated for each State lines of business as appropriate:

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

The Contractor shall offer Provider Policies and Procedures Manual training to all network providers when they are initially enrolled in the network, whenever there are changes in policies or procedures, and upon a provider's request. Updates or changes in operation that require revisions to the Provider Policies and Procedures Manual shall be submitted to OMPP for review and approval in accordance with the requirements outlined in Section 8.7.1.

8.7.3 Education for HIP Providers

For HIP providers, the Contractor shall provide education and outreach about the different HIP benefit plans, including the separate PDL for HIP State Plan and formulary for HIP Plus and HIP Basic benefits; medically frail policies and procedures; POWER Accounts, including preventive care and roll over; co-payments for emergency room services; co-payments for HIP Basic and HIP State Plan Basic services; and the POWER Account and payment procedures.

The Contractor shall also educate its HIP providers about its pregnancy-related services and policies. Such education shall emphasize that members will transition to the HIP Maternity (MAMA) benefit plan.

Provider education shall also include information about member cost-sharing, including the five percent (5%) cap on cost-sharing, and the requirement that providers reduce or waive member co-payments if notified by the Contractor or the State that the member's family has exceeded the five percent (5%) cap on member cost-sharing. Any notification to providers shall identify the time period during which the co-payments shall be reduced or waived.

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8.8 Contractor Communications with Providers

The Contractor shall have in place policies and procedures to maintain frequent communications and provide information to its provider network. As required by 42 CFR 438.207(c), which sets notification requirements, the Contractor shall notify OMPP of material changes, as described in Section 2.10, that may affect provider procedures at least thirty (30) calendar days prior to notifying its provider network of the changes. The Contractor shall give providers at least forty-five (45) calendar days advance notice of material changes that may affect the providers' procedures such as changes in subcontractors, claims submission procedures or prior authorization policies. The Contractor shall post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

All public facing communications from the Contractor's subcontractors must be approved by FSSA and meet the same timeframe as the contractor's requirement.

Because some pharmacy services are covered by Indiana Medicaid FFS under the pharmacy benefit consolidation, Contractors shall educate providers about which pharmacy services should be submitted to the State fiscal agent for reimbursement, and which should be submitted to the Contractor. The Contractor shall also ensure that providers receive education about the different PDLs applicable to the various HIP benefit plans, and that they have readily available information regarding a member's applicable PDL.

In accordance with 42 CFR 438.102, which relates to provider-enrollee communications, the Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member. Contractor shall communicate this clearly to all providers.

8.8.1 Provider Website

The Contractor shall develop and maintain a website in an FSSA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines for network and out-of-network providers. The website shall be live and meet the requirements of this section on the effective date of the Contract. OMPP shall pre-approve the Contractor's website information and graphic presentations. The Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website described in Section 7.4.2.

To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor shall date each web page, change the date with each revision and allow users print access to the information. The provider website may have secured information available to network providers but shall, at a minimum, have the following information available to all providers:

- Contractor's contact information;
- Provider Policy and Procedure Manual and associated forms;
- All of Contractor's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic;

- Claim submission information including, but not limited to the Contractor submission and processing requirements, paper and electronic submission procedures, emergency room auto-pay lists and frequently asked questions;
- Provider claims dispute resolution procedures for contracted and out-of- network providers;
- Prior authorization procedures, including a complete list of services which require prior authorization;
- Appeal procedures;
- Entire network provider listings;
- Links to FSSA and OMPP websites for general Medicaid and HIP information;
- HIPAA and 42 CFR Part 2 Privacy Policy and Procedures

8.8.2 Provider Services Helpline

The Contractor shall maintain a toll-free telephone helpline for all providers with questions, concerns or complaints. With the exception of the holidays listed below, the Contractor shall staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a twelve (12)-hour business day, from 8 a.m. to 8 p.m. Eastern, Monday through Friday. The provider helpline may be closed on the following holidays: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas.

The Contractor may request that additional days, such as the day after Thanksgiving, be authorized for limited staff attendance. This request shall be submitted to OMPP at least thirty (30) calendar days in advance of the date being requested for limited staff attendance and must be approved by OMPP. For all days with a closure, early closing or limited staff attendance, there shall be a process for providers to process emergency prior authorizations as needed. Call center closures, limited staffing or early closures shall not burden a member's access to care.

The Contractor shall maintain a system for tracking and reporting the number and type of provider calls and inquiries. The Contractor shall monitor its provider helpline and report its telephone service performance to OMPP each quarter as described in the HIP MCE Reporting Manuals.

8.8.3 IHCP Workshops and Seminars

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

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

The Contractor shall develop policies and procedures to prohibit the payment of charges for certain hospital acquired conditions and “never events.” These policies and procedures shall be approved by OMPP prior to implementation and upon any subsequent change.

In accordance with 42 CFR 434.6(a)(12), 42 CFR 438.3(g) and 42 CFR 447.26 no payment shall be made by the Contractor to a provider for a provider-preventable condition as identified in the State Plan. All payments made by Contractor for “never events” shall be recovered by the Contractor and/or OMPP as prescribed in section 10.4 Program Integrity Overpayment Recovery.

The Contractor’s policies on non-payment of certain hospital-acquired conditions shall comply with 405 IAC 1-10.5-5 and the IHCP Provider Bulletin regarding Present on Admission Indicator for Hospital Acquired Conditions dated August 25, 2009 (BT200928), as well as any updates or amendments thereto.

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’s policy on non-payment of certain never events shall be developed in accordance with current Medicare National Coverage Determinations (NCDs), as well as any Indiana Medicaid FFS rules or other guidance adopted or issued by OMPP at a future date.

8.10 Member Payment Liability

In accordance with 42 CFR 438.106, which relates to liability for payment, the Contractor and its subcontractors shall provide that members are not held liable for any of the following:

- Any payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly;
- Covered services provided to the member for which OMPP does not pay the Contractor;
- Covered services provided to the member for which OMPP 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 shall ensure that its providers do not balance bill its members, i.e., charge the member for covered services above the amount paid to the provider by the Contractor. If the Contractor is aware that an out-of-network, non-IHCP provider, such as an out-of-state emergency services provider, is balance billing a member, the Contractor shall instruct the provider to stop billing the member and to enroll in the IHCP in order to receive reimbursement from the Contractor. The Contractor shall also contact the member to help resolve issues related to the billing.

IHCP providers are prohibited from charging a member, or the family of the member, for

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

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

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

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

non-covered services.

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

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

This section should not be interpreted as interfering with a provider's ability to hold HIP members liable for the emergency services co-payment or HIP Basic or HIP State Plan Basic member liability for allowable copayment amounts set forth in Section 4.1.2.

Further, this section should not be interpreted as preventing payment of covered services with POWER Account funds before the member's deductible has been met. However, if the Contractor permits providers to bill members for services that require authorization, but for which authorization is denied, as outlined above, POWER Account funds shall not be used to reimburse the provider for the non-covered service.

8.11 Provider Directory

The Contractor shall develop a searchable provider directory. A printed copy of the provider directory shall also be available to members and OMPP upon request. The Contractor may use the same provider directory for its Indiana State Medicaid lines of business as long as the directory clearly designates which population(s) the provider serves.

In accordance with 42 CFR 438.10(h), the provider directory shall include the following information:

- Lists of PMPs, the PMPs' service locations (including county), phone numbers, office hours, type of PMP (i.e., family practice, general practitioners, general internists, general pediatricians, obstetricians and gynecologists, and internal medicine physicians specializing in pediatrics or endocrinology) and whether the PMPs are accepting new members;

- Lists of specialty providers (including behavioral health providers and community mental health centers), their service locations (including county), phone numbers, office hours, type of specialty;

- Lists of hospital providers, home care providers and all other network providers;

- Lists of in-network pharmacies serving HIP members, their service locations, and phone numbers;

- Languages spoken by the provider or the provider's office personnel;

- Provider web sites, if applicable; and

- If the provider has accommodations for people with physical disabilities.

The Contractor shall include the aforementioned provider network information in an OMPP- approved format (compliant with Section 508 of the US Rehabilitation Act) on its member website. The Contractor shall list provider network information by county on the Contractor's website and update the information every two (2) weeks. Network provider information shall be available to print from a remote user location.

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8.12 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 Medicaid fee schedule rate multiplied by the HAF factor OR 100% of the Medicaid Inpatient APR DRG rate multiplied by the HAF factor.
  - Non-contracted providers: MCEs shall pay according to administrative code 405 IAC 10-9-4 (b) and State statute IC 12-15-44.5-5 multiplied by the HAF factor.

- Non-HAF eligible hospitals
  - Contracted providers: MCEs shall pay 100% of the Medicare rate or 130% of the Medicaid rate when no Medicare rate exists..
  - Non-contracted providers: MCEs shall pay according to administrative code 405 IAC 10-9-4 (b) and State statute IC 12-15-44.5-5.

8.13 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 non-physician staff such as nurses, physician assistants, midwifes, social workers, psychologists, and optometrists.

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

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

9.0 Quality Management and Utilization Management

The Contractor shall monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members in the HIP program by all providers in all types of settings, in accordance with the provisions set forth in this Scope of Work. In compliance with state and federal regulations, the Contractor shall submit quality improvement data, including data that meets HEDIS standards for reporting and measuring outcomes, to OMPP that includes the status and results of performance improvement projects. Additionally, the Contractor shall submit information requested by OMPP to complete the State's annual Quality Strategy Plan for CMS.

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For purposes of this Section 9, the following definitions apply. A “performance improvement project” shall mean a plan to remediate an identified program deficiency in response to a sanction or action by OMPP. A “quality improvement project” is a planned strategy for program improvement and is incorporated into the Contractor’s Quality Management and Improvement Program Work Plan.

9.1 Quality Management and Improvement Program

The Contractor’s Medical Director shall be responsible for the coordination and implementation of the Quality Management and Improvement Program. The program shall have objectives that are measurable, realistic and supported by consensus among the Contractor’s medical and quality improvement staff. Through the Quality Management and Improvement Program, the Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services to members. As a key component of its Quality Management and Improvement Program, the Contractor shall develop incentive programs for both providers and members, with the ultimate goal of encouraging appropriate utilization of health care resources and improving health outcomes of HIP members. The Contractor may establish different provider and member incentives for its HIP populations.

As a part of the Contractor’s Quality Management and Improvement Program, the Contractor shall participate in OMPP’s annual performance improvement program.

The Contractor shall meet the requirements of 42 CFR 438 subpart E on Quality Assessment and Performance Improvement and the National Committee for Quality Assurance (NCQA), including but not limited to the requirements listed below, in developing its Quality Management and Improvement Program and the Quality Management and Improvement Program Work Plan. In doing so, it shall include (i) an assessment of quality and appropriateness of care provided to members with special needs, including all medically frail HIP members; (ii) complete performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects; and (iii) produce quality of care reports at least annually.

The Contractor’s Quality Management and Improvement Program shall:

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

- Have in effect mechanisms to detect both underutilization and overutilization of services. The activities the Contractor takes to address underutilization and overutilization must be documented.

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

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

- Participate appropriately in clinical studies, and use Healthcare Effectiveness

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Data and Information Set ® (HEDIS®) rate data and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members. In assessing the quality and appropriateness of care provided to members under 21 years of age, the Contractor must act in accordance with EPSDT/Health Watch requirements.

- Collect measurement indicator data related to areas of clinical priority and quality of care. OMPP will establish areas of clinical priority and indicators of care. OMPP reserves the right to identify additional conditions at any time, as the areas reflect the needs of the Indiana Medicaid populations. These areas may vary from one year to the next and from program to program. Examples of areas of clinical priority include:

    - HIV and Hepatitis C care
    - Behavioral health and physical health care coordination;
    - Immunization rates;
    - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
    - Prenatal care;
    - Postpartum care;
    - Emergency room utilization;
    - Access to care;
    - Special needs care coordination and utilization;
    - Asthma;
    - Obesity,
    - Tobacco dependence treatment, especially for pregnant women;
    - Inpatient and emergency department follow-up;
    - Timely follow-up and notification of results from preventive care; and
    - Integrated medical and behavioral health utilization.

- Report any national performance measures developed by CMS in the future. The Contractor must develop an approach for meeting the desired performance levels established by CMS upon release of the national performance measures, in accordance with 42 CFR 438.330(a), which allows CMS to specify measures and topics for performance improvement projects.

- Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector. The CMS website contains an example of available protocols.

- Develop and maintain a physician incentive program, as described in Section 9.2.1.

- Develop a member incentive program to encourage members to be personally accountable for their own health care and health outcomes, as described in Section 9.2.2. Targeted areas of performance could include the appropriate use of emergency room services, keeping appointments and scheduling appointments for routine and preventive services such as prenatal care, disease screenings, compliance with behavioral health drug therapy, compliance with diabetes treatment and well-child visits.

- Participate in any state-sponsored prenatal care coordination programs.

- Contract for an NCQA-accredited HEDIS audit and report audited HEDIS

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rates. A separate HEDIS audit is required for the Contractor's HIP lines of business. The HEDIS audit and report must be based upon the NCQA methodology for sampling of HEDIS data.

- Conduct a Consumer Assessment of Health Plans (CAHPS) survey and report survey results to OMPP annually. A separate CAHPS survey is required for the Contractor's HIP lines of business. The CAHPS survey must be based upon the NCQA methodology for sampling of CAHPS data.

- Include a provider relations project annually.

- Participate in other quality improvement activities, including External Quality Reviews, to be determined by OMPP.

9.1.1 Quality Management and Improvement Committee

The Contractor shall establish an internal Quality Management and Improvement Committee to develop, approve, monitor and evaluate the Quality Management and Improvement Program and Work Plan. The same committee may be responsible for all of the Contractor's Medicaid lines of business. The Contractor's Medical Director and Pharmacy Director shall be active participants in the Contractor's internal Quality Management and Improvement Committee. The committee shall be representative of management staff, including provider relations, Contractor departments and community partners, advocates, members and subcontractors, as appropriate. Subcontractors providing direct services to members shall be represented on the committee.

The Contractor shall have appropriate personnel attend and participate in OMPP's regularly scheduled Quality Strategy Committee meetings. The Contractor is encouraged to recommend attendees and other stakeholders to Quality Strategy Committee meetings. Additionally, the Medical Director shall attend and participate in OMPP's Quality Strategy Committee meetings at least quarterly to update OMPP and report on the Contractor's quality management and improvement activities and outcomes.

The Contractor shall have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, the Contractor's internal Quality Management and Improvement Committee and Quality Management and Improvement Program Work Plan. All functional units in the Contractor's organizational structure shall integrate their performance measures, operational activities and outcome assessments with the Contractor's internal quality management and improvement committee to support the Contractor's quality management and improvement goals and objectives.

9.1.2 Quality Management and Improvement Program Work Plan Requirements

The Contractor's Quality Management and Improvement Committee, in collaboration with the Contractor's Medical Director and Pharmacy Director, shall develop an annual Quality Management and Improvement Program Work Plan. The plan shall identify the Contractor's quality management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals. One plan shall be developed for the Contractor's HIP line of business. The plan shall meet the HEDIS standards for reporting and measuring outcomes. The plan shall incorporate any quality improvement projects identified for the HIP program.

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

The Contractor shall submit its Quality Management and Improvement Program Work Plan to OMPP during the readiness review and annually thereafter. The Contractor shall provide progress reports to OMPP on no less than a quarterly basis. The Contractor must be prepared to periodically report on its quality management activities to OMPP's Quality Strategy Committee.

The Contractor shall prepare the annual Quality Management and Improvement Program Work Plan using standardized reporting templates provided by OMPP. The HIP MCE Reporting Manuals, contain instructions for the annual Quality Management and Improvement Program Work Plan and Quality Improvement Plans.

9.1.3 External Quality Review

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

9.2 Incentive Programs

OMPP shall require Contractors to participate in a pay for outcomes program that focuses on rewarding Contractors' efforts to improve quality and outcomes for HIP members. OMPP shall provide, at minimum, financial performance incentives to Contractors based on performance targets in priority areas established by the State. The Contractor incentives and performance targets will be set forth in Exhibit 4.

OMPP shall have the right to revise measures on an annual basis and will notify the Contractor of changes to incentive measures.

Quality measures may target the following:

- Preventive care;
- Pregnancy;
- Chronic disease care including HIV and Hepatitis C;
- Pharmacy services;
- Tobacco dependence treatment;
- Behavioral health follow-up services;
- Emergency and inpatient utilization; and
- Medically frail identification (HIP Only).

Additional conditions to payment of incentive amounts are provided in Exhibit 4.

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

9.2.1 Provider Incentive Programs

Contractors shall establish a performance-based incentive system for its providers for the Contractor's HIP providers. Different provider incentives may be established for the different Medicaid lines of business. The Contractor will determine its own methodology for incentivizing providers. The Contractor shall obtain OMPP-approval prior to implementing its provider incentive program and before making any changes thereto. The State encourages creativity in designing pay for performance programs.

If the Contractor offers financial incentives to providers, these payments shall be above and beyond the standard Medicare fee-for-service schedule.

Section 1876(i)(8) of the Social Security Act and federal regulations 42 CFR 438.10(f)(3), 42 CFR 422.208 and 42 CFR 422.210 provide information regarding physician incentive plans. The Contractor shall comply with all federal regulations regarding the physician incentive plan and supply to OMPP information on its plan as required in the regulations and with sufficient detail to permit OMPP to determine whether the incentive plan complies with the federal requirements. The Contractor shall provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.

Physician incentive plans shall comply with the following requirements:

- The Contractor will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member;

- The Contractor meets requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.10(f)(3); and

- The Contractor will expand the provider incentive plans and align them with the following healthy incentive program focus areas: tobacco cessation, substance use disorder treatment, chronic disease management, and employment related incentives.

9.2.2 Member Incentive Programs

Contractors shall establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or non- financial. The Contractor will determine its own methodology for providing incentives to members, subject to OMPP review and approval. For example, the Contractor may offer member incentives for:

- Attending all prenatal visits;

- Obtaining recommended preventive care;

- Completing the expected number of EPSDT visits;

- Complying with treatment in a disease management, care management or complex case management program;

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- Making healthy lifestyle decisions such as quitting smoking or losing weight;
- Completing a health screening;
- Participation in tobacco cessation;
- Participation in substance use disorder treatment;
- Participation in chronic disease management; or
- Participation in employment related incentives.

1. Except as provided herein, the Contractor may not offer gifts or incentives greater than $200.00 for each incentive and not to exceed $300.00 total per year per individual, unless an exception is approved by OMPP. The Contractor may petition OMPP, in the manner prescribed by OMPP, for authorization to offer items or incentives greater than $200.00 for each individual and $300.00 per year per individual if the items are intended to promote the delivery of certain preventive care services, as defined in 42 CFR 1003.101. Such incentives may not be disproportionate to the value of the preventive care service provided, as determined by OMPP. Petitions to provide enhanced incentives for preventive care shall be reviewed on a case-by-case basis, and OMPP shall retain full discretion in determining whether the enhanced incentives will be approved. In any member incentive program, the incentives shall be tied to appropriate utilization of health services and/or health-promoting behavior. For example, the member incentive programs can encourage responsible emergency room use or preventive care utilization. Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and encourage the receipt of health care services in the appropriate treatment setting. Additionally, the Contractor shall comply with those requirements found in 42 CFR 1003.101, “Remuneration…(4) Incentives given to individuals to promote the delivery of preventive care services where the delivery of such services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or an applicable State health care program. Such incentives may include the provision of preventive care, but may not include—

   (i) Cash or instruments convertible to cash; or

   (ii) An incentive the value of which is disproportionally large in relationship to the value of the preventive care service (*i.e.,* either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care)…”

2. Examples of appropriate rewards include:

   - Gift certificates for groceries;
   - Phone cards; or
   - Gifts such as diaper bags or new baby “welcome” kits.

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The Contractor shall obtain OMPP-approval prior to implementing its member incentive program and before making any changes thereto.

9.2.3 Notification of Pregnancy (NOP) Incentives

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

The provider shall be responsible for completing the standard NOP form, including member demographics, any high-risk pregnancy indicators, and basic pregnancy information. The Contractor receiving the NOP shall contact the member to complete a comprehensive pregnancy health risk assessment within twenty-one (21) calendar days of receipt of completed NOP form from the provider. Only one assessment should be completed per member per pregnancy, regardless of whether the member receives pregnancy services through the Presumptive eligibility for pregnant women program. NOP requirements and conditions for payment are set forth in the HIP MCE Policies and Procedures Manual.

To be eligible for the provider incentive payment, the NOP form shall be submitted by providers via the Portal within five (5) calendar days of the visit during which the NOP form was completed. The State shall reimburse the Contractor for NOP forms submitted according to the standards set forth in the HIP MCE Policies and Procedures Manual. This reimbursement amount shall be passed on to the provider who completed the NOP form. An additional amount will be transferred to a bonus pool. The Contractor shall be eligible to receive bonus pool funds based on achievement of certain maternity-related targets. See Exhibit 4 for further detail regarding the NOP incentives and maternity-related targets.

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

9.3 Utilization Management Program

The Contractor shall operate and maintain its own utilization management program. The Contractor may place appropriate limits on coverage on the basis of medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose. 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.

The Contractor shall 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. The Contractor may accept a nationally recognized set of guidelines, including but not limited to Milliman Care Guidelines or InterQual. 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

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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), relating to authorization of services, the Contractor shall consult with contracting health care professionals in developing practice guidelines and shall 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. The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines to providers' requests for health care or service authorizations for the Contractor's members. The Contractor shall periodically review and update the guidelines, distribute the guidelines to providers and make the guidelines available to members upon request. Utilization management staff shall receive ongoing training regarding interpretation and application of the utilization management guidelines. The Contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by OMPP.

The Contractor shall require its providers to utilize the standardized Indiana Health Coverage Programs Prior Authorization Request Form for the submission of all prior authorization requests. In addition, the State reserves the right to standardize certain parts of the prior authorization reporting process across the MCEs, such as requiring the MCEs to adopt and apply the same definitions regarding approved, pended, denied, suspended requests, etc. When adopted, these standards shall be set forth in the MCE Reporting Manual.

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

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

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

The Contractor's utilization management program shall not be limited to traditional utilization management activities, such as prior authorization. The Contractor shall maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The utilization management program shall have policies and procedures and systems in place to assist utilization management staff to identify instances of over- and under-utilization of

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emergency room services and other health care services, identify aberrant provider practice patterns (especially related to emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams), ensure active participation of a utilization review committee, evaluate efficiency and appropriateness of service delivery, incorporate subcontractor's performance data, facilitate program management and long-term quality and identify critical quality of care issues.

The Contractor's utilization management program shall link members to disease management, case management and care management, as set forth in Sections 6.7 and 6.8. The Contractor's utilization management program shall also encourage health literacy and informed, responsible medical decision making. For example, Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting.

Contractors shall also be responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

The Contractor shall monitor utilization through retrospective reviews and will identify areas of high and low utilization and identify key reasons for the utilization patterns. The Contractor shall identify those members that are high utilizers of emergency room services and/or other services and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, case management or care management services. The Contractor shall also use this data to identify additional disease management programs that are needed. Any member with emergency room utilization at least three (3) standard deviations outside of the mean for the population group shall be referred to an appropriate level of care coordination. The Contractor may use the Right Choices Program (RCP), as described in Section 9.3.1 below, in identifying members to refer to case management or care management.

The Contractor shall monitor the pharmacy utilization of all its members where the Contractor is not responsible for paying or reimbursing the pharmacy services.

As part of its utilization review, the Contractor shall monitor access to preventive care, specifically to identify members who are not accessing appropriate preventive care services in accordance with accepted preventive care standards, such as those published by the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, or OMPP's recommended preventive care guidelines (for HIP). The Contractor shall develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards.

In order to monitor potential under- or over-utilization of behavioral health services, OMPP requires Contractors to provide separate utilization reports for behavioral health services. The Contractor shall particularly monitor use of services for its members with special needs and members with a diagnosis of severe mental illness or substance abuse. The behavioral health services report shall also separately identify the utilization of HIP members designated as medically frail.

9.3.1 The Right Choices Program (RCP)

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. 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,

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implement restrictions for those members who would benefit from increased care coordination. The Contractor will provide appropriate disease management, care management or complex case management services to RCP members.

Program policies, set forth by the OMPP are delineated in the Right Choices Program Policy Manual. The Contractor shall comply with the program policies set forth in this Manual and subsequent revisions.

The Contractor shall be responsible for RCP duties, as outlined in the Right Choices Program Policy Manual, including, but not limited to, the following:

- Evaluate claims (including medical and pharmacy claims), medical information, referrals and data to identify members to be enrolled in the RCP— before enrolling a member in the RCP, the Contractor shall ensure a physician, pharmacist or nurse confirms the appropriateness of the enrollment;
- Document member enrollment and compliance in Portal;
- Enroll members in the RCP;
- Provide written notification of RCP status to such members and their assigned primary physicians, pharmacies and/or hospitals;
- Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management and/or 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— the State shall make available utilization data about the Contractor's RCP members to assist the Contractor in its monitoring duties;
- Notify OMPP of members that are being reported to the OMPP Bureau of Investigation for suspected or alleged fraudulent activities;
- Complete periodic reports about RCP to OMPP upon request;
- Cooperate with OMPP in evaluation activities of the program by providing data and/or feedback when requested by OMPP;
- Meet with OMPP about RCP program implementation as requested by OMPP; and
- Develop, obtain OMPP approval of and implement internal policies and procedures regarding the Contractor's RCP program administration, and use of any subcontractors with the RCP members

OMPP shall monitor the Contractor's compliance with the RCP duties set forth in this Scope of Work and the Right Choices Program Policy Manual through its monthly onsite visits and/or external quality review activities. The Contractor may be subject to the non- compliance remedies as set forth in Exhibit 4 if the

Contractor fails to comply with the RCP duties set forth in this Scope of Work and the Right Choices Program Policy Manual. OMPP reserves the right to review pharmacy and emergency room utilization figures for the Contractor's RCP membership, including the number of RCP members who have had more than one emergency room visit in a thirty (30)-calendar day period, in assessing the effectiveness of the Contractor's RCP program administration.

9.3.2 Authorization of Services and Notices of Actions

Clinical professionals who have appropriate clinical expertise in the treatment of a member's condition or disease shall make all decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. Only licensed physicians and nurses may deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested. The Contractor shall not provide incentives to utilization management staff or to providers for denying, limiting or discontinuing medically necessary services. OMPP may audit Contractor denials, appeals and authorization requests. OMPP 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 OMPP. If the Contractor delegates some or all of its prior authorization function to subcontractors, the Contractor shall conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures and state and federal law.

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

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

- Special Needs: In accordance with 42 CFR 438.208(c), 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 or an approved number of visits. Treatment provided by the specialist must be appropriate for the member's condition and identified needs.

- Women's Health: In accordance with 42 CFR 438.206(b)(2), the Contractor must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist. The Contractor must have an established mechanism to permit a female member direct access such as a standing referral from the member's PMP or an approved number of visits. The

Contractor may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

The Contractor shall track all prior authorization requests in their information system. All notes in the Contractor's prior authorization tracking system shall be signed by clinical staff and include the appropriate suffix (e.g., RN, MD, etc.). For prior authorization approvals, the Contractor shall provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name of caller, (ii) title of caller, (iii) date and time of call, and (iv) prior authorization number.

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

The Contractor shall provide a written notice to the member and provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.404, "Notice of Action." The notice to members shall be provided at a fifth grade reading level.

The notice shall be given within the timeframes described in the following paragraphs and 42 CFR 438.404(c).

The notification letters used by the Contractor shall be approved by OMPP 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 subcontractor has taken or intends to take;
- The reasons for the action;
- The member's or the provider's right to file an appeal with the Contractor and the process for doing so;
- The procedure to request a State fair hearing following exhaustion of the Contractor's appeal process;
- Circumstances under which expedited resolution is available and how to request it;
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services; and
- The provider's right for a peer to peer utilization review conversation with the reviewer and timeline for requesting the peer to peer review.

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Unless otherwise provided in or 405 IAC 10, the Contractor shall 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 OMPP 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 OMPP upon request. Extensions require written notice to the member and shall include the reason for the extension and the member's right to file a grievance.

Unless otherwise provided or 405 IAC 10 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 OMPP upon request.

The Contractor shall notify members in writing of decisions to terminate, suspend or reduce previously authorized covered services, including transfers between HIP benefit plans that result in a change to covered services, at least ten (10) calendar days before the date of action, with the following exceptions:

- Notice is shortened to five (5) calendar days if probable member fraud has been verified by the Indiana Office of the Inspector General or Attorney General.

- 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).

9.3.3 Objection on Moral or Religious Grounds

If the Contractor elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it shall furnish information about the services it does not cover as follows, in accordance with 42 CFR 438.102(b):

- To OMPP 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.

9.3.4 Utilization Management Committee

The Contractor shall have a utilization management committee directed by the Contractor's Medical Director. The same committee may be responsible for all State Medicaid lines of business. The committee shall be responsible for:

- Monitoring providers' requests for rendering health care services to its members;
- Monitoring the medical appropriateness and necessity of health care services provided to its members;
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed;
- Writing policies and procedures for utilization management that conform to industry standards including methods, timelines and individuals responsible for completing each task; and
- Confirming the Contractor has an effective mechanism in place for a plan provider or Contractor representative to respond within one hour to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days-a-week:

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- 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.

10.0 Program Integrity

The Indiana Office of the Attorney General, Medicaid Fraud Control Unit is the state agency responsible for the investigation of provider fraud in the Indiana Medicaid program. The OMPP Program Integrity Unit (OMPP PI), is responsible for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of Medicaid-eligible beneficiaries, and referring cases of suspected fraud to the MFCU for investigation. The OMPP PI Unit identifies and recovers Medicaid waste and abuse. The FSSA Bureau of Investigations evaluates and investigates reports of suspected fraud by recipients of assistance programs and both government and contract employees.

The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting, including business transaction disclosure reporting (42 CFR 455.105) and the full ownership and control information (42 CFR 455.104) and shall further provide any additional information necessary for the FSSAS to perform exclusion status checks pursuant to 42 CFR 455.436. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and the terms of this Contract, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at any time upon request.

The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax- reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any services provided by excluded individuals shall be refunded to and/or obtained by the State and/or the Contractor as prescribed in Section 10.4 Program Integrity Overpayment Recovery. Where the excluded individual is the provider of services or an owner of the provider, all amounts paid to the provider shall be refunded.

The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities. Staffing levels, at a minimum, will be equal to one full-time staff member for every 100,000 members in addition to the Special Investigation Unit Manager and the Compliance Director.

The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. The Contractor shall also provide all documentation and information requested by OMPP PI Unit or required under this section and its subsections in the form and manner mandated by the OMPP PI Unit.

10.1 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 PI Unit, and updated quarterly, or more frequently if required by the OMPP Program Integrity (PI) Unit, be submitted to OMPP. The PI Plan and/or updates to the PI Plan shall be submitted through the reporting process to OMPP, who shall forward to the OMPP PI Unit, ten (10) business days prior to scheduled meetings discussing the Plan. The Plan shall include in its PI Plan provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of 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 Unit at a minimum of quarterly and as directed by the OMPP PI Unit.

- The type and frequency of training and education for the Special Investigation Unit Manager, Compliance Officer, and the organization's employees who will be provided to detect fraud. Training must be annual and address the False Claims Act, Indiana laws and requirements governing Medicaid reimbursement and the utilization of services – particularly changes in rules, and other Federal and state laws governing Medicaid provider participation and payment as directed by CMS and FSSA. Training should also focus on recent changes in rules.

- A risk assessment of the Contractor's various fraud and abuse/program integrity process. For 2020 and all years afterwards, a risk assessment shall also be submitted on an "as needed" basis or at a minimum of every 6 months. This assessment shall also include a listing of the MCEs top three vulnerable areas and shall outline action plans mitigating such risks.

- An organizational chart and communication plan highlighting lines of communication between the Special Investigation Unit Manager, the Compliance Officer and the organization's employees.

- Provision for internal monitoring and auditing.

- Procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this contract.

- A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:

    - A list of automated pre-payment claims edits.
    - A list of automated post-payment claims edits.
    - A list of types of desk audits on post-processing review of claims.
    - A list of reports for provider profiling and credentialing used to aid program and payment integrity reviews.
    - A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.
    - A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials.

- A list of references in provider and member material regarding fraud and abuse referrals.
- A list of provisions for the confidential reporting of PI Plan violations to the designated person.
- A list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports.

- Provisions ensuring that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.

- Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance PI Plan violations.

- Requirements regarding the reporting of any confirmed or suspected provider fraud and abuse under state or federal law to the OMPP PI Unit and pursuant to Section 10.2 below.

- Assurances that no individual who reports Contractor's potential violations or suspected fraud and abuse is retaliated against.

- Policies and procedures for conducting both announced and unannounced site visits and field audits to providers defined as high risk (including but not limited to providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

- Provisions for prompt response to detected offenses, and for development of corrective action initiatives.

- Program integrity-related goals, objectives and planned activities for the upcoming year.

10.2 Program Integrity Operations

The Contractor shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard Medicaid funds against improper payments and unnecessary or inappropriate use of Medicaid. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected waste, fraud and abuse activities. Contractor shall have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud and abuse issues of Contractor's providers, vendors, and subcontractors (including Pharmacy Benefits Managers) and Contractor itself). Contractor is required to conduct and maintain at a minimum the following operations and capabilities. Contractor shall conduct all operations and deploy all capabilities described below on a routine basis and as necessary for the effective reduction of Medicaid waste, fraud and abuse.

- The Special Investigation Unit within the Contractor's structure shall have the ability to make referrals to the OMPP PI Unit, and accept referrals from a variety of sources including: directly from providers (either provider self-referrals or from other providers), members, law enforcement, government agencies, etc. The Contractor shall also have effective procedures for timely reviewing, investigating,

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and processing such referrals.

- The Contractor will suspend all payments to a provider after the Agency determines that there is a credible allegation of fraud and has provided the Contractor with written notice of a payment suspension.

- Data mining, analytics, and predictive modeling for the identification of potential overpayments and aberrant payments/providers warranting further review/investigation.

- Provider profiling and peer comparisons of all of Contractor's provider types and specialties – at a minimum annually - to identify aberrant service and billing patterns warranting further review/audit.

- Onsite Audit capability and protocols identifying how and when the Special Investigation Unit shall conduct such onsite audits of providers.

- Medical claim audit capabilities sufficient to enable the Special Investigation Unit to audit any payment issued to any provider. This includes utilizing medical record reviewers, clinicians, coding specialists, accountants, and investigators needed for review of payments to any provider/provider type.

- Member service utilization analytics to identify members that may be abusing services. Contractor shall submit to FSSA for approval the criteria utilized for its review of its members and the referral of members to the Right Choices Program.

10.3 Program Integrity Reporting

The Contractor shall cooperate with all appropriate state and federal agencies, including the Indiana MFCU and the OMPP PI Unit, in investigating fraud and abuse. The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21). Contractor shall provide an Audit Report to OMPP and the OMPP PI Unit. The Audit Report documents all provider and member-specific program integrity activities of Contractor (i.e., the specific application of Program Integrity Plan provisions to identify specific provider and member waste, fraud and abuse), as documented below.

The Contractor shall immediately report all suspected or confirmed instances of waste, fraud and abuse to the OMPP and the OMPP PI Unit. 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 4 for willful failure to report fraud and abuse by providers, Medicaid beneficiaries/members, or applicants to the OMPP PI Unit as appropriate. All confirmed or suspected cases of waste, fraud and abuse shall be discussed at the Managed Care-Program Integrity coordination meeting following the OMPP PI Unit's receipt of the report unless otherwise directed by the OMPP PI Unit.

The Contractor shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the Contractor shall not take any of the following actions as they specifically relate to Indiana claims:

- Contact the subject of the investigation about any matters related to the investigation;
- Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- The Contractor shall promptly provide the results of its preliminary investigation to the OMPP PI Unit or to another agency designated by the OMPP PI Unit.
- The Contractor shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
- The Contractor shall suspend all payments to a provider after FSSA determines that there is a credible allegation of fraud and has provided the Contractor with a notice of a payment suspension.

On a quarterly basis, and as otherwise directed by the OMPP PI Unit, the Contractor shall submit a detailed Audit Report to OMPP which outlines the Contractor's program integrity-related activities, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives. The Audit Report shall specify current audits, reviews, claim denials, and investigation activity of the unit, a summary of the reason for the audit/investigative activity, the disposition of any such completed activity (including detailed overpayment amounts identified or recouped), and projected upcoming activity for the following quarter. The Audit Report should also specify individual provider recoupment, repayment schedules, and actions taken for each audit or investigation. The quarterly progress report must identify recoupment totals for the reporting period. The Audit Report shall also identify projected upcoming activity, including the top 20 providers on Contractor's list for audit, and the type(s) of audit(s) envisioned. The OMPP PI Unit shall review and approve, approve with modifications, or reject the Audit Report and specify the grounds for rejection. Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the OMPP PI Unit) must also be submitted in the Audit Report.

In accordance with 42 CFR 438.608(d)(3), the 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.

10.4 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.

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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 Unit, FSSA may recover any identified overpayment directly from the provider or may require Contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Unit. The OMPP PI Unit may also take disciplinary action against any provider identified by Contractor or the OMPP PI Unit as engaging in inappropriate or abusive billing or service provision practices.

If a fraud referral from Contractor generates an investigation and/or corresponding legal action results in a monetary recovery to IHCP, the reporting Contractor will be entitled to share in such recovery following final resolution of the matter (settlement agreement/final court judgment) and following payment of recovered funds to the State of Indiana. The Contractor's share of recovery will be as follows:

- From the recovery, the State (including the IMFCU) shall retain its costs of pursuing the action, including any costs associated with OMPP PI Unit operations associated with the investigation, and its actual documented loss (if any). The State will pay to the Contractor the remainder of the recovery, not to exceed the Contractor's actual documented loss. Actual documented loss of the parties will be determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.

- If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the Contractor about potential settlement. The State may consider the Contractor's preferences or opinions about acceptance, rejection or the terms of a settlement, but they are not binding on the State.

- If final resolution of a matter does not occur until after the Contract has expired, the preceding terms concerning disposition of any recovery and consultation with the Contractor shall survive expiration of the Contract and remain in effect until final resolution of a matter referred to the IMFCU by the Contractor under this section.

If the State makes a recovery from a fraud investigation and/or corresponding legal action where the Contractor has sustained a documented loss but the case did not result from a referral made by the Contractor, the State shall not be obligated to repay any monies recovered to Contractor, but may do so at its discretion. Funds recovered as a result of a multi-state fraud investigation/litigation, however, will be shared with Contractor as prescribed for funds recove4red 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

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state or federal audit, investigation and/or lawsuit, including but not limited to false claims act cases;

- When the issue, services or claims that are the basis of the repayment have been or are currently being investigated by the OMPP PI Unit, the Federal Medicaid Integrity Contractor (MIC), Contractor, Indiana MFCU, or Assistant United State Attorney (AUSA), are the subject of pending Federal or State litigation, or have been/are being audited by the State Recovery Audit Contractor (RAC).

This prohibition described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The Contractor shall check with the OMPP PI Unit before initiating any repayment of any program integrity related funds to ensure that the repayment is permissible.

10.5 Auditing Program Integrity Operations

The OMPP PI Unit may conduct audits of 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 Unit may issue a corrective action or performance improvement plan and outline timelines for improvement measures. The failure to adhere to operational improvement measures may result in the State's imposing liquidated damages up to the amount of overpayments recovered from Contractor's providers by OMPP PI Unit audits for the preceding calendar year, or imposing other non-compliance remedies including liquidated damages as outlined by Exhibit 4.

11.0 Information Systems

The Contractor shall have an Information System (IS) sufficient to support the HIP program requirements, and the Contractor shall be prepared to submit all required data and reports accurately and completely in the format specified by OMPP. These reports shall be accurate and complete. The Contractor shall maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Scope of Work. HIP member benefit plan assignment, including any applicable medically frail designation or pregnancy diagnosis.

In the event the State's technical requirements require amendment during the term of the Contract, the State will work with Contractors in establishing the new technical requirements. The Contractor shall be capable of adapting to any new technical requirements established by the State, and the State may require the Contractor to agree in writing to the new requirements. After the Contractor has agreed in writing to a new technical requirement, any Contractor-initiated changes to the requirements shall require OMPP approval and OMPP 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 OMPP 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 OMPP 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 OMPP upon request in the timeframe and manner specified by the State.

The Contractor shall have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164), which address security and privacy of individually identifiable health information.

The Secretary of the Department of Health and Human Services (HHS) has adopted ASC X12 version 5010 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009 and all covered entities must be fully compliant on January 1, 2012. Contractors must complete an internal gap analysis to compare their current systems against the 5010 standard. Completion of such analysis will be verified during the readiness review. The Contractor must be ready to begin testing in the 5010 format with the State's fiscal agent and other vendors on January 1, 2017. Readiness to test will be demonstrated during the readiness review process.

The Contractor's IS shall support HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier requirements and Privacy and Security Rule standards. The Contractor's electronic mail encryption software for HIPAA security purposes shall provide no less protection than the State's electronic mail encryption software. The Contractor's IS plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308);
- Physical safeguards (45 CFR 164.310); and
- Technical safeguards (45 CFR 164.312).

The Contractor shall have the ability to do the following for GTW:

- Receive monthly GTW batch files;
- Develop a report or upload with ACHIEVE for incentive hours per MID per month;
- Include year to date GTW Monthly Status on each participant's monthly statements; and
- Export a GTW exemption request file containing: MID, exemption code, exemption reason, effective date, number of months exemption lasts, case notes, and error codes.

The Contractor shall make data available to OMPP and, upon request, to CMS. In accordance with 42 CFR 438, subpart H, which relates to certifications and program integrity, the Contractor shall submit all data, including encounter claims, under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the Contractor's data. The Contractor shall comply with all Indiana Office of Technology (IOT) standards, policies and guidelines, which are available online at http://in.gov/iot/2394.htm. All hardware, software and services provided to or purchased by the State shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d) and IC 4-13.1-3. Any deviation

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from these architecture requirements shall be approved in writing by IOT in advance. In addition to the IOT policies, the Contractor shall comply with all OMPP Application Security Policies. Any deviation from the policies shall be approved in writing from OMPP.

11.1 Disaster Recovery Plans

Information system contingency planning shall be developed in accordance with the requirements of this Section and with 45 CFR 164.308, which relates to administrative safeguards. Contingency plans shall include: Data Backup plans, Disaster Recovery plans and Emergency Mode of Operation plans. Application and Data Criticality analysis and Testing and Revisions procedures shall also be addressed within the Contractor's contingency plan documents. The Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternative location under emergency conditions within twenty-four (24) hours of identification of a disaster. The Contractor shall protect against hardware, software and human error. The Contractor shall maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back- ups and disaster recovery. The Contractor shall maintain full and complete back-up copies of data and software, and shall back up on tape or optical disk and store its data in an off-site location approved by OMPP.

For purposes of this Scope of Work, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Contractor's or its subcontracting entities' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. The Contractor shall take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status. Disasters may include natural disasters, human error, computer virus or malfunctioning hardware or electrical supply.

The Contractor shall notify OMPP, 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, OMPP, in its discretion, may require the Contractor to provide OMPP a detailed plan for resuming operations. In the event of a catastrophic or natural disaster (including, but not limited to, fire, flood, earthquake, storm, hurricane, war, invasion, act of foreign enemies, or terrorist activities), the Contractor shall resume normal business functions at the earliest possible time, not to exceed thirty (30) calendar days. If deemed appropriate by the State, the Contractor shall coordinate with the State fiscal agent to restore the processing of claims by *Core*MMIS if the claims processing capacity cannot be restored within the Contractor's system. In the event of other disasters or system unavailability caused by the failure of systems and technologies within the Contractor's span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply), the Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten (10) calendar days.

The Contractor and HIP subcontractors' responsibilities include, but are not limited to:

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- Supporting immediate restoration and recovery of lost or corrupted data or software.

- Establishing and maintaining, in an electronic format, a weekly back-up and a daily back- up that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations and user documentation.

- Demonstrating an ability to meet back-up requirements by submitting and maintaining Data Backup and Disaster Recovery Plans that address:

    - Checkpoint and restart capabilities and procedures;
    - Retention and storage of back-up files and software;
    - Hardware back-up for the servers;
    - Hardware back-up for data entry equipment; and
    - Network back-up for telecommunications.

- Developing coordination methods for disaster recovery activities with OMPP and its contractors to ensure continuous eligibility, enrollment and delivery of services.

- Providing the State with business resumption documents, reviewed and updated at least annually, such as:

    - Disaster Recovery Plans
    - Business Continuity and Contingency Plans
    - Facility Plans
    - Other related documents as identified by the State

At no additional charge to the State, the Contractor shall be required to have in a place a comprehensive, fully tested IT business continuity/disaster recovery plan (ITBCP) with respect to the system and services it provides to the State:

- The ITBCP will, at a minimum, meet the requirements of NIST SP800-34.

- The State and the Contractor will mutually agree on reasonable Recovery Point Objectives and Recovery Time Objectives reflective of the State's business requirements and the critical nature of the Contractor's systems and services in support of the associated State business operations:

    - At a minimum, the Recovery Time Objectives will be no more than 48 hours;
    - At a minimum, the Recovery Point Objectives will be no more than 24 hours;
    - These Objectives will be reviewed and, as necessary, modified on an annual basis.
    - The Contractor will coordinate its ITBCP with OMPP's own IT business continuity/disaster recovery plans, including other State solutions with which the Contractor's system interfaces to assure appropriate, complete, and timely recovery:
    - The Contractor agrees to coordinate the development, updating, and testing of its ITBCP with the State in the State's development,

updating, and testing of its Continuity of Operations Plan (COOP), as required by State policy and Homeland Security Presidential Directive (HSPD) 20.

- The ITBCP will be based on the agreed upon Recovery Point Objectives and Recovery Time Objectives, and a comprehensive assessment of threat and risk to be performed by the Contractor, with such threat and risk assessment updated on no less than annually by the Contractor (to reflect technological, Contractor business, and State business operations changes, and other appropriate factors).

- The State expects the Contractor's ITBCP to be tested by Contractor no less than annually, with such testing being comprehensive in nature and scope assuring point-to- point testing in meeting the agreed upon Recovery Point Objectives and Recovery Time Objectives.

    - The first test of the Contractor's ITBCP is expected to be performed within ninety
      (90) calendar days of the State's award of a contract to the Contractor.

- The Contractor will provide the State with an annual report regarding the Contractor's (no less than) annual testing and updating of its ITBCP, including the results of the annual test, including failure points and corrective action plans.

    - The first such report is expected within thirty (30) calendar days of the Contractor's completion of its first test of its ITBCP.

- The Contractor will submit to the State a copy of its ITBCP, including annual updates.

    - The first copy of the ITBCP will be expected within ninety (90) calendar days of the State's award of a contract to the Contractor.

- The Contractor further agrees to make reasonable updates and changes to its ITBCP as requested from time-to-time by the State or as otherwise may be required by applicable federal or state laws and regulations.

11.2 Member Enrollment Data Exchange

The Contractor shall be responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member. The Contractor shall reconcile its eligibility and capitation records monthly. For the Contractor's HIP members, the monthly reconciliation shall also include a reconciliation of any state POWER Account contributions and/or recoupment records received during the month. If the Contractor discovers a discrepancy in eligibility, capitation or POWER Account payment information, the Contractor shall notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records. The Contractor shall return any capitation or POWER Account overpayments to OMPP within forty-five (45) calendar days of discovering the discrepancy. The HIP MCE Policies and Procedures Manual details the terms for reconciling eligibility and underpayments of capitation back to the Contractor. If the Contractor receives either enrollment information or capitation for a member, and/or a state POWER Account contribution for a HIP member, the Contractor is financially responsible for the member.

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The Contractor shall accept enrollment data in electronic format, currently via secure file transfer protocol ("FTP"), as directed by FSSA and as detailed in the Indiana Health Coverage Program Companion Guide – 834 Contractor Benefit Enrollment and Maintenance Transaction ("834 Companion Guide), which shall be updated by FSSA prior to the Contract effective date to include updated HIP protocols. FSSA shall have the right to amend the 834 Companion Guide during the Contract term. The Contractor is responsible for loading the eligibility information into its claims system within five (5) calendar days of receipt. See the MCE834 Companion Guide for more information regarding enrollment data exchange and enrollment rosters.

The Contractor's information systems shall accommodate the State's 12-digit member identification number (MID) for each member.

11.3 Provider Network Data

The Contractor shall submit provider network information to the State fiscal agent via the Portal. The Contractor shall keep provider enrollment and disenrollment information up-to- date. The Contractor shall enter updates into the Portal no less frequently than on the 1st and 15th day of each month. For more information regarding provider network data, please refer to the HIP MCE Policies and Procedures Manual.

11.4 Claims Processing

11.4.1 Claims Processing Capability

The Contractor shall demonstrate and maintain the capability to process and pay provider claims for services rendered to the Contractor's members, in compliance with HIPAA, including National Provider Identification (NPI). The Contractor shall be able to price specific procedures or encounters (depending on the agreement between the provider(s) and the Contractor) and to maintain detailed records of remittances to providers. OMPP must pre- approve the Contractor's delegation of any claims processing function to a sub-contractor, and the Contractor must notify OMPP and secure OMPP's approval of any change to sub- contracting arrangements for claims processing.

The Contractor shall develop policies and procedures to monitor claims adjudication accuracy and shall submit its policies and procedures for monitoring its claims adjudication accuracy to OMPP 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 with the filing limit under the Medicaid state plan (42 CFR 447.45(d)(4)). The in-network provider filing limit is established in the Contractor's provider agreements pursuant to the guidelines set forth in Section 8.4, which generally require in-network providers to submit claims within ninety (90) calendar days from the date of service.

The Contractor shall have written policies and procedures for registering and responding to claims disputes for out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6-1.

11.4.2 Compliance with State and Federal Claims Processing Regulations

The Contractor shall have a claims processing system to support electronic claims submission for both in- and out-of-network providers. The Contractor's system shall

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process all claim types such as professional and institutional claims. The Contractor shall comply with the claims processing standards and confidentiality standards under IC 12-15-13-1.6 and IC 12-15-13-1.7, and any applicable federal regulations, including HIPAA regulations related to the confidentiality and submission requirements for protected health information (PHI). The Contractor shall ensure that communication with providers, particularly out-of- network providers, and submission requirements are efficient and not burdensome for any providers. The Contractor shall be prohibited from requiring out-of-network providers to establish a Contractor-specific provider number in order to receive payment for claims submitted.

11.4.3 Claims Payment Timelines

The Contractor shall pay providers for covered medically necessary services rendered to the Contractor's members in accordance with the standards set forth in IC 12-15-13-1.6 and IC 12-15-13-1.7, unless the Contractor and provider agree to an alternate payment schedule and method. The Contractor shall also abide by the specifications of 42 CFR 447.45(d)(5) and (d)(6), which require the Contractor to ensure that the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

The Contractor shall pay or deny electronically filed clean claims within twenty one (21) calendar days of receipt. A "clean claim" is one in which all information required for processing the claim is present. The Contractor shall pay or deny clean paper claims within thirty (30) calendar days of receipt. If the Contractor fails to pay or deny a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, the Contractor shall also pay the provider interest at the rate set forth in IC 12-15-21- 3(7)(A). The Contractor shall pay interest on all clean claims paid late (i.e., in- or out-of- network claims) for which the Contractor is responsible, unless the Contractor and provider have made alternate written payment arrangements.

As provided in 42 CFR 447.46(c)(2), the Contractor may, by mutual agreement, establish an alternative payment schedule with in-network providers. The alternative payment schedule shall be outlined in the provider agreement described in Section 8.4. However, the alternate payment schedule shall not violate the claims payment provisions and timeframes that apply to accident and sickness insurers and HMOs under IC 27-8-5.7 and IC 27-13-36.2.

OMPP shall have the right to perform a random sample audit of all claims, and expects the Contractor to fully comply with the requirements of the audit and provide all requested documentation, including provider claims and encounters submissions.

11.5 POWER Account Systems

The Contractor shall have an IS that is capable of automating the required POWER Account transactions, including the 820, 834 and PRF transactions, in compliance with the data specifications set forth in the State fiscal agent's Companion Guides. The Contractor shall provide real-time access to member POWER Account balances in a secure format.

The Contractor shall have policies, procedures and mechanisms in place to support the POWER Account requirements set forth in the HIP MCE Policies and Procedures Manual

and the State fiscal agent's Companion Guides, as may be amended from time to time. The Contractor shall have policies, procedures and mechanisms in place to support accuracy, security and privacy in the Contractor's administration of member POWER Accounts. The contractor shall conform to state and federal requirements for ensuring member financial and debit card information is secure.

11.6 Encounter Data Submission

The Contractor shall have policies, procedures and mechanisms in place to support the encounter data reporting process described below and in the State's Companion Guides. The Contractor shall strictly adhere to the standards set forth in the State fiscal agent's Companion Guides, as may be amended from time to time, such as the file structure and content definitions (including any content definitions as may further be interpreted or defined by FSSA). The quality of Contractor's encounter data submissions shall be subject to audit and validation. Contractor shall fully comply with all such audit and validation activities including, but not limited to, attending meetings, providing background information on encounter data submissions, providing access to systems, records, and personnel that can assist auditors with their work, and timely responding to all information requests from the State or its auditors.

The Contractor technical meetings with FSSA and the Fiscal Agent provide a forum for Contractor technical support staff to participate in the development of the data exchange process and ask questions related to data exchange issues, including encounter data transmission and reporting issues. The Contractor shall report any problems it is experiencing with encounter data submissions and reporting at this monthly meeting and to its designated OMPP Contract Compliance Manager.

11.6.1 Definition and Uses of Encounter Data

The Contractor shall submit an encounter claim to the State fiscal agent 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 shall use the encounter data to make tactical and strategic decisions related to the HIP 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 4 for a schedule of liquidated damages that OMPP will assess for non-compliance with encounter data submission requirements.

11.6.2 Reporting Format and Batch Submission Schedule

The Contractor shall submit institutional, pharmacy, dental, vision, transportation and other professional encounter claims in an electronic format that adheres to the data specifications in the State fiscal agent's Companion Guides and any other state or federally mandated electronic claims submission standards, or be subject to liquidated damages. A diagnosis code and DRG, as applicable, is a required data field and shall be included on all encounter claims. The Contractor's encounter

claims shall include the National Drug Codes (NDCs) when an encounter involves products or services with NDCs, including medical and institutional claims where medications with NDCs are included and billed separately. An indication of claim payment status and an identification of claim type (i.e., original, void or replacement) is also required, in the form designated by FSSA.

The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week, or other date and time as specified by the State. OMPP 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 4 for a schedule of liquidated damages OMPP 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.

11.6.3 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 all encounter claims within fifteen (15) months of the earliest date of service on the claim. The Contractor shall submit void/replacement claims within two (2) years from the date of service. In addition, the Contractor shall submit ninety eight percent (98%) of adjudicated claims within twenty-one (21) calendar days of adjudication. The State will require the Contractor to submit a corrective action plan to address timeliness issues and will assess liquidated damages if the Contractor fails to comply with encounter claim timeliness requirements.

- Compliance with Pre-cycle Edits: Each encounter claim shall be reviewed for compliance with pre-cycle edits. The Contractor shall correct and resubmit any encounter claims that do not pass the pre-cycle edits. The State shall require the Contractor to submit a corrective action plan to address non-compliance issues and will assess liquidated damages if the Contractor fails to comply with 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. OMPP shall have the right to monitor Contractor encounter claims for accuracy against the Contractor's internal criteria and its level of adjudication accuracy. OMPP 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. OMPP 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. OMPP 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. OMPP 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 OMPP's completeness requirements as described in Exhibit 4.

OMPP 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.

11.7 Third Party Liability (TPL) Issues

If a member is also enrolled in or covered by another insurer, the Contractor is fully responsible for coordinating benefits so as to maximize the utilization of third party coverage. The Contractor shall share information regarding its members, especially those with special health care needs, with other payers as specified by OMPP and in accordance with 42 CFR 438.208(b), which relates to coordination of care. In the process of coordinating care, the Contractor shall protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164, which address security and privacy of individually identifiable health information.

The Contractor shall be responsible for payment of the member's coinsurance, deductibles, co- payments and other cost-sharing expenses, but the Contractor's total liability shall not exceed what the Contractor would have paid in the absence of TPL, after subtracting the amount paid by the primary payer. The Contractor shall coordinate benefits and payments with the other insurer for services authorized by the Contractor,

but provided outside the Contractor's plan. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the member or provider of service by the Contractor shall not prevent or unduly delay a member from receiving medically necessary services. The Contractor remains responsible for the costs incurred by the member with respect to care and services which are included in the Contractor's capitation rate, but which are not covered or payable under the other insurer's plan.

The Contractor must have a signed Coordination of Benefits Agreement (COBA) with CMS and participate in the automated crossover claim process administered by Medicare.

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.

11.7.1 Coordination of Benefits

If the HIP member primary insurer is a commercial HMO and the Contractor cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the Contractor's rules, the Contractor may submit to the Enrollment Broker a written request for disenrollment. The request shall provide the specific description of the conflicts and explain why benefits cannot be coordinated. The Enrollment Broker will consult with OMPP and the request for disenrollment will be considered and acted upon accordingly.

The types of other insurance coverage the Contractor should coordinate with include insurance such as worker’s compensation insurance and automobile insurance.

11.7.2 Collection and Reporting

The Contractor will be responsible for identifying, collecting and reporting third party liability coverage and collection information to the State. As third party liability information is a component of capitation rate development, the Contractor shall maintain records regarding third party liability collections and report these collections to OMPP in the timeframe and format determined by OMPP.

11.7.3 Cost Avoidance

The Contractor’s TPL responsibilities include cost avoidance. When the Contractor is aware of other insurance coverage prior to paying for a health care service for a member, it should avoid payment by rejecting a provider's claim and direct that the provider first submit the claim to the appropriate third party. The Contractor shall be allowed to keep some or all of the costs it recovers from the third party, as set forth in Section 11.7.2 above.

When it 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
- 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 shall make the payment and make a claim against the third party, if it is determined that the third party is or may be liable. The Contractor shall ensure that its cost avoidance efforts do not prevent a member from receiving medically necessary services in a timely manner.

11.7.4 Cost Avoidance Exceptions

Cost avoidance exceptions in accordance with 42 CFR 433.139, which relates to third-party liability, include the following situations in which the Contractor shall first pay the provider and then coordinate with the liable third party:

- The claim is for prenatal care for a pregnant woman and the service occurred before May 1, 2020. For dates of service on or after May 1, 2020, this exception no longer applies.
- The claim is for labor, delivery and post-partum care, and does not involve hospital costs associated with the inpatient hospital stay.
- The claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program.
- The claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within thirty (30) calendar days after the date of service.
- The claim is for services provided that were covered by a third party at the time services were rendered or reimbursed (i.e., the Contractor was not aware of the third party coverage); the Contractor shall pursue reimbursement from potentially liable third parties.

11.8 Health Information Technology and Data Sharing

The use of Health Information Technology (HIT) has the potential to improve the quality and efficiency of health care delivery in numerous ways. Digitizing and sharing health care data can reduce medical errors, increase efficiency, decrease duplicative or unnecessary services and reduce fraud and abuse. Additionally, HIT initiatives are important in improving the data quality necessary for public health research, evidenced-based decision-making, population health management and reduction of manual, labor-intensive monitoring and oversight.

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

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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.

Contractors should develop, implement and participate in HIT and data sharing initiatives in order to improve the quality, efficiency and safety of health care delivery in Indiana. The Contractor shall also cooperate and participate in the development and implementation of future FSSA-driven HIT initiatives.

Contractors shall be required to enter into data sharing agreements with any health information technology entity that the State enters into data sharing agreements with.

OMPP reserves the right to require Contractors to establish personal health records (PHRs) for its members in the future. A PHR is an electronic health record of the member that is maintained by the Contractor. PHRs typically include a summary of member health and medical history such as diagnoses, allergies, family history, lab results, vaccinations, surgeries, etc., and may also include claims information. In the event the State adopts a standard PHR format, the Contractor shall be required to implement the State's standard format. The Contractor shall also be required to incorporate its member portal information and, for HIP members, POWER Account balance information into the PHR.

In addition to a PHR, the following are examples of other types of HIT initiatives that the Contractor may consider developing:

- **Electronic medical record (EMR).** An electronic medical record provides for electronic entry and storage of patients' medical record data. Depending on the local information technology infrastructure, EMRs may also allow for electronic data transmission and data sharing. More complex EMRs can integrate computerized provider order entry (CPOE) and e-prescribing functions.

- **Inpatient computerized provider order entry (CPOE).** CPOE refers to a computer-based system of ordering diagnostic and treatment services, including laboratory, radiology and medications. A basic CPOE system promotes legible and complete order entry and can provide basic clinical decision support such as suggestions for drug doses and frequencies. More advanced CPOE systems can integrate with an EMR for access to a patient's medical history.

- **Health information exchanges (including regional health information organizations – RHIOs).** These exchanges, such as the Indiana Health Information Exchange, allow participating providers to exchange clinical data electronically. The capacity of health information exchanges varies. Some initiatives provide electronic access only to lab or radiology results, while others offer access to shared, fully integrated medical records.

- **Benchmarking.** 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 live interactions, and is especially useful in situations where members do not have easy access to a provider, such as for members in rural areas. Providers also use telemedicine to consult with each other and share their expertise for the benefit of

treating complex patients in HIP. Contractors are encouraged to develop reimbursement mechanisms to encourage appropriate use of telemedicine.

- **Mobile and Self-Service Technology**. The Contractor is encouraged to utilize mobile and self-service technology in delivering services to members. This includes, but is not limited to, remote monitoring devices to enable members to record health measures for delivery to the Contractor and/or physician practices and medication and appointment reminders through personalized voice or text messages.

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 encouraged to use these standards in developing their electronic data sharing initiatives, if any.

Currently, resources and infrastructure for HIT vary widely throughout Indiana. There are multiple strategies and tactics that Contractors can adopt to participate directly and to incent providers to participate in HIT. Some examples include:

- Contract or affiliate with existing health information exchanges and information networks;
- Develop coalitions with other health care providers to develop health information exchanges and information networks;
- Develop proposals for health information exchanges and information networks, and apply for grants to support those proposals;
- Require providers to participate in one of Indiana's established health data exchanges or information networks, in regions where those networks are currently established;
- Require high-volume prescribers to use some level of e-prescribing;
- Require high-volume providers to use EMRs;
- Identify providers that are and are not currently participating in information networks or using EMRs, e-prescribing, CPOE or other HIT in order to focus incentives; and
- Offer incentives to providers for adopting HIT, such as:
    - Provide free or subsidized handheld devices to physicians for electronic prescribing; and
    - Provide financial or non-financial incentives to providers who adopt EMRs or electronic prescribing.

12.0 Performance Reporting and Incentives

The State places great emphasis on the delivery of quality health care to HIP members. Performance monitoring and data analysis are critical components in assessing how well the

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Contractor is maintaining and improving the quality of care delivered in the HIP program. The State uses various performance targets, industry standards, national benchmarks and program-specific standards in monitoring the Contractor's performance and clinical outcomes. The Contractor shall submit performance data specific to the HIP program unless otherwise specified by OMPP. The State reserves the right to publish the HIP program's performance and/or recognize the Contractor when it exceeds performance indicators.

The Contractor shall comply with all reporting requirements set forth in this Section 12, as well as the HIP MCE Reporting Manuals. The Contractor shall submit the requested data completely and accurately within the requested timeframes and in the formats identified by OMPP. The State reserves the option to require more frequent reporting for performance improvement (e.g., on a weekly or a monthly basis), until Contractor demonstrates that its performance is consistent and meets the State's requirements and standards. 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 shall have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to OMPP is accurate. In accordance with 42 CFR 438.604 and 42 CFR 438.606, the Contractor shall submit its performance data and reports under the signatures of either its Financial Officer or Executive Officer (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the Contractor's data. The MCE Reporting Manual details the reporting requirements that are highlighted below.

OMPP reserves the right to audit the Contractor's 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 Exhibit 4, for Contractor non-compliance with these and other subsequent reporting requirements and performance standards. OMPP may change the frequency of reports and may require additional reports. OMPP shall provide at least thirty (30) calendar days' notice to the Contractor before changing reporting requirements. OMPP may request ad hoc reports at any time. See the MCE Reporting Manuals for detail regarding OMPP's 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.

12.1 Financial Reports

Financial Reports assist OMPP 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, OMPP shall notify the Contractor of the non-compliance and designate a period of time, not less than ten (10) calendar days, during which the Contractor shall provide a written response to the notification. Contractors shall meet the IDOI licensure and financial requirements. Examples of Financial Reports to be submitted by the Contractor, in accordance with the terms of the MCE Reporting Manuals, include but are not limited to:

- Financial Stability Indicators – includes Third Party Liability Collections;
- IDOI Filing;
- Reimbursement for FQHC and RHC Services;
- Physician Incentive Plan Disclosure;

- Insurance Premium Notice;
- Stop Loss; and
- Medical Loss Ratio.

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.

12.2 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. Examples of Member Service Reports to be submitted by the Contractor, in accordance with the terms of the MCE Reporting Manuals, include but are not limited to:

- Member Helpline Performance Report, including reason codes for member calls;
- 24-Hour Nurse Call Line Performance Report;
- Member Grievances Report;
- Member Appeals Report;
- Member Grievances Log;
- Member Appeals Log;
- FSSA Hearing and Appeals;
- Summary of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey;
- Member Website Utilization Report, including EOB and quality information hits;
- POWER Account Contribution Collection Report;
- Marketing and Outreach Report;
- Redetermination Outreach Report, including all outreach activities related to redetermination; and
- GTW required member communication compliance and GTW Assistance Planning outreach compliance (e.g. Automated calls, live calls, etc.).

OMPP shall have the right to require more frequent Member Service reporting, especially at the beginning of the Contract and during implementation of program changes as necessary to ensure satisfactory levels of member service throughout the Contract term.

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12.3 Network Development Reports

Network Development Reports assist OMPP in monitoring the Contractor's network composition by specialty and geo-access ratios in order to assess member access and network capacity. The Contractor shall identify current enrollment, gaps in network services and the corrective actions that the Contractor is taking to resolve any potential problems relating to network access and capacity. Examples of Network Development Reports to be submitted by the Contractor, in accordance with the terms of the MCE Reporting Manuals, include but are not limited to:

- Network Geographic Access Assessment, including PMPs, Specialists, Behavioral Health, Dental and Pharmacy Providers;
- Twenty four (24)-Hour Availability Audit;
- Subcontractor Compliance Summary Report; and
- Provider Directory.

OMPP will require more frequent Network Geographic Access Assessment reporting at the beginning of the Contract and during implementation of program changes as necessary to ensure satisfactory network access, until the Contractor demonstrates that the network access standards have been met.

12.4 Provider Service Reports

Provider Service Reports assist OMPP in monitoring the methods the Contractor uses to communicate to providers about clinical, technical and quality management and improvement issues relating to the program. Examples of Provider Service Reports to be submitted by the Contractor, in accordance with the terms of the MCE Reporting Manuals, include but are not limited to:

- Provider Helpline Performance Report;
- Formal Provider Claims Disputes;
- Provider Credentialing Timeframes;
- Binding Arbitration; and
- Results of Provider Surveys.

12.5 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 OMPP in monitoring the Contractor's quality management and improvement activities. Examples of Quality Management Reports to be submitted by the Contractor, in accordance with the terms of the MCE Reporting Manuals, include but are not limited to:

- Quality Management and Improvement Program Work Plan;

- Quality Management Committee Meeting Minutes;
- Quality Improvement Program and Pay-for-Outcomes Statistical Analysis;
- HEDIS Data Submission Tool;
- HEDIS Auditor Report;
- Disease Management Report;
- Case/Care Management Reports; and
- New Member Health Screenings Report.

12.6 Utilization Reports

Utilization Reports assist OMPP in monitoring the Contractor's utilization trends to assess its stability and continued ability to offer health care services to its members. Examples of Utilization Reports to be submitted by the Contractor, in accordance with the terms of the MCE Reporting Manuals and this Scope of Work, including but are not limited to:

- Program Integrity Plan;
- Prior Authorization Report;
- Emergency Department Co-payment Waivers obtained through the 24-Hour Nurse Call Line;
- Pharmacy Utilization Reports (HIP only);
- Capitation Rate Calculation Sheet; and
- Maternity Capitation Rate Calculation Sheet.

12.7 Claims Reports

These reports assist OMPP in monitoring the Contractor's claims processing activities to ensure appropriate member access to services and payments to providers. The Contractor shall submit claims processing and adjudication data. The Contractor shall also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing. Examples of Claims Reports to be submitted by the Contractor, in accordance with the terms of the MCE Reporting Manuals, include but are not limited to:

- Adjudicated Claims Summary, including Claims Aging Summary and Claims Lag Report;
- Top 10 Claims Denial Reasons; and
- Claims Processing Summary, including Outstanding Claims Inventory Summary and Interest Paid on Claims.

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12.8 HIP Reports

Due to HIP's unique program design, the Contractor shall also be required to provide the reports specific to its HIP line of business. Examples of HIP Reports to be submitted by the Contractor, in accordance with the terms of the HIP MCE Reporting Manual, include but are not limited to:

- POWER Account Summary;
- Benefit Design Summary, including benefit plan transfer data;
- Preventive Care Report;
- GTW Report;
- Roll-Over Report;
- Pregnancy Identification Report;
- Medically Frail Identification Report; and
- Tobacco Surcharge Report.

The Contractor shall be prepared to break out HIP data (such as enrollment data, non-payment of POWER Account contribution data and other POWER Account data) in a manner requested by the State according to various member characteristics, including, but not limited to HIP benefit package, medically frail status, and/or FPL category.

12.9 CMS Reporting

The Contractor shall be required to submit data requested by the Centers for Medicare and Medicaid Services (CMS), including but not limited to all required MCE reporting obligations described in the CMS Special Terms and Conditions (STCs) for the State's waiver. For example, in addition to the specific reports described in the STCs, CMS often requests additional data and reports in advance of OMPP's monthly conference calls with CMS. In preparation for these calls, OMPP will ask the Contractor for data requested by CMS. The Contractor shall submit this data in the timeframe specified by OMPP.

In addition, the Contractor shall cooperate with OMPP in meeting all other CMS required HIP reporting activities, whether specifically set forth in the CMS STCs for the State's waiver, or as otherwise requested by CMS. The Contractor agrees to submit data for the HIP quarterly and annual reports to OMPP in a timeframe and format as requested by OMPP, as set forth in the HIP MCE Reporting Manual. For any reports not specifically set forth in the HIP MCE Reporting Manual, the State will submit any such reporting and data requests directly to the Contractor's Compliance Officer.

12.10 Unclaimed Refunds or Property Report

The Contractor shall document all unclaimed refunds and property on a monthly basis and submit a detailed report in a manner prescribed by OMPP identifying all such refunds and property, in addition to sending this information to the Indiana Attorney General's Office.

Unclaimed refunds should include all checks that are refunds due to a member or checks written to a provider (i.e., “expenditure payouts,” etc.) that for whatever reason are not cashed by the member or provider. If no refunds were submitted during a period, the report must be submitted indicating "No Refunds Submitted to the Attorney General During This Month." The Contractor is responsible for assuring that all of its subcontractors/vendors submit the same reports monthly or that Contractor’s report captures the relevant information from subcontractors/vendors.

12.11 Other Reporting

OMPP shall have the right to require additional reports to address program-related issues that are not anticipated at the Contract start date but are determined by OMPP to be necessary for program monitoring.

13.0 Failure to Perform/Non-compliance Remedies

13.1 Non-compliance Remedies

It is the State’s primary goal to ensure that the Contractor is delivering quality care to members. To assess attainment of this goal, the State monitors certain quality and performance standards, and holds the Contractor accountable for being in compliance with Contract terms. OMPP accomplishes this by working collaboratively with the Contractor to maintain and improve programs, and not to impair health plan stability.

In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Exhibit 4, or the Contractor Reporting Manual, the State will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies discussed in Exhibit 4. 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 or Exhibit 4 in a particular instance, this decision shall 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.

13.2 Evidence of Financial Responsibility

The Contractor shall provide a performance bond of standard commercial scope issued by a surety company registered with the IDOI or other evidence of financial responsibility to guarantee performance by the Contractor of its obligations under the Contract. A separate performance bond or other evidence of financial responsibility in the amount of $1,000,000 is required for the Contractor’s HIP lines of business.

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 shall, in addition to any other remedies it may have under the Contract, obtain payment under the performance bond or other arrangement for the purposes of the following:

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

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of the State.

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

14.0 Termination Provisions

14.1 Contract Terminations

FSSA shall have the right to terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any 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 parties may be terminated on the following basis listed below:

- By the Contractor, subject to the remedies listed in the Contract.
- By the State, in whole or in part, whenever the State determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within sixty (60) 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.
- By the State, in whole or in part, whenever funding from state, federal or other sources are withdrawn, reduced or limited, with sufficient prior notice to the Contractor.
- By the State, in whole or in part, whenever the State determines that the instability of the Contractor's financial condition threatens delivery of Medicaid services and continued performance of Contractor responsibilities.

The State shall provide the Contractor with a hearing prior to contract termination in accordance with 42 CFR 438.708, which relates to MCE contract termination.

14.1.1 Termination by the State for Contractor Default

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor or a subcontractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within sixty (60) calendar days, or such other reasonable period of time as specified in writing by the State, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the State that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the State will notify the Contractor that the Contract, in full or in part, has been terminated for default.

If, after notice of termination for default, it is determined by the State or by a court

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of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the State, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided under this clause, the State may procure, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the State for costs incurred to procure such similar supplies or services as are needed to continue operations.

In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined in the Contract.

In the event of a termination for default during ongoing operations, the Contractor will be paid for any outstanding capitation payments due, less any assessed damages.

The rights and remedies of the State provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

14.1.2 Termination for Financial Instability

FSSA may terminate the Contract immediately upon the occurrence of any of the following events:

- The Contractor becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under the Contract;
- The Contractor ceases to conduct business in normal course;
- The Contractor makes a general assignment for the benefit of creditors; or
- The Contractor suffers or permits the appointment of a receiver for its business or assets.

The State may, at its option, immediately terminate the Contract effective at the close of business on the date specified. In the event the State elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor shall immediately advise the Contract Administrator as specified in the Contract between the State and the Contractor. The Contractor shall ensure that all tasks related to the subcontract are performed in accordance with the terms of the Contract.

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14.1.3 Termination for Failure to Disclose Records

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor has failed to make available to any authorized representative of the State, any administrative, financial and medical records relating to the delivery of services for which state Medicaid and/or CHIP program dollars have been expended.

In the event that the State terminates the Contract pursuant to this provision, the Contractor shall be notified in writing, either by certified or registered mail, either sixty (60) calendar days prior to or such other reasonable period of time prior to the effective date, of the basis and extent of the termination. Termination shall be effective as of the close of business on the date specified in the notice.

14.1.4 Termination by the Contractor

The Contractor shall give advance written notice of termination, or intent not to renew, to the State a minimum of one hundred and eighty (180) calendar days prior to termination. The effective date of the termination shall be no earlier than the last day of the month in which the one hundred and eightieth (180th) day falls. Termination of the Contract by the Contractor is subject to damages listed in Section 14.4.

14.2 Termination Procedures

When termination is anticipated, OMPP shall deliver to the Contractor written notice of termination by certified or registered mail specifying the nature of the termination and the date upon which such termination becomes effective ("Notice of Termination"). Within ten (10) calendar days of receipt of the Notice of Termination, the Contractor shall develop and submit a written plan to termination ("Transition Plan") for OMPP's approval. The Transition Plan shall, at minimum address the following:

- Stopping work under the Contract, on the date and to the extent specified in the Notice of Termination.
- Placing no further orders or subcontracts for materials, services or facilities.
- Notifying all of the Contractor's members regarding the date of termination and the process by which members will continue to receive medical care. For its HIP members, the Contractor shall also explain how they will have access to POWER Account funds. OMPP must approve all member notification materials in advance of distribution.
- Terminating all orders and subcontracts, to the extent that they relate to the performance of work terminated by the Notice of Termination.
- Assigning activities to the State, its designee or successor contractor, in the manner and to the extent that they relate to the performance of work terminated by the Notice of Termination.
- Assigning to the State, its designee or successor MCE, in the manner and to the extent directed, all of the rights, titles and interests of the Contractor under the orders or subcontracts so terminated.

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- With the approval of the State, settling outstanding liabilities and all claims arising out of such termination of orders and subcontracts.

- With the approval of the State, establishing a plan for transferring member POWER Account funds and related information to the State, its designee or the successor MCE.

- Within ten (10) business days from the effective date of the termination, transferring title to the State of Indiana (to the extent that title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information and documentation, in any form that relates to the work terminated by the Notice of Termination.

- Completing the performance of such part of work that has not been specified for termination by the Notice of Termination.

- Taking such action as may be necessary, or as the State may direct, for the protection and preservation of the property related to the Contract that is in the possession of the Contractor and in which the State has or may acquire an interest.

- Providing for all the Contractor's responsibilities set forth in Section 14.3 below.

The requirements listed above are illustrative only and do not limit or restrict the State's ability to require the Contractor to address additional issues in its Transition Plan.

The State shall withhold the Contractor's final capitation payment until the Contractor has 1) received FSSA approval of its Transition Plan and 2) completed the activities set forth in its Transition Plan, as well as any additional activities requested by FSSA, to the satisfaction of FSSA. Satisfactory completion of the Contractor's transition responsibilities pursuant to the FSSA- approved Transition Plan shall be made at the sole discretion of FSSA.

14.3 Contractor Responsibilities Upon Termination or Expiration of the Contract

Termination or expiration of the Contract does not discharge the obligations of the Contractor with respect to services or items furnished prior to termination or expiration of the Contract, including retention of records and verification of overpayments or underpayments. Termination or expiration of the Contract does not discharge the State's payment obligations to the Contractor or the Contractor's payment obligations to its subcontractors and providers. Upon termination or expiration of the Contract, the Contractor shall:

- Assist the State in taking the necessary steps to ensure a smooth transition of services after expiration or termination of the Contract.

- Provide a written Transition Plan for the State's approval in accordance with Section14.2. In the event of Contract termination, the Transition Plan shall be due within ten (10) calendar days of receiving Notice of Termination from the State. In the event of Contract expiration, the Transition Plan shall be due at least one hundred and eighty (180) calendar days prior to expiration of the Contract. The Contractor will revise and resubmit the Transition Plan to the State on a regular basis, the frequency of which will be determined by the State.

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

- Appoint a liaison for post-transition concerns

- Provide for sufficient claims payment staff, member services staff, POWER Account staff and provider services staff to ensure a smooth transition.

- Provide the State with all information requested by the State in the format and within the timeframes set forth by the State, which shall be no later than thirty (30) calendar days of the request, including for HIP members up-to-date data about POWER Account balances, annual and lifetime benefit totals and member utilization of recommended preventive services.

- Assist the State and/or its subcontractors in FQHC/RHC settlement process for settlement periods prior to the day of termination or expiration of the Contract. Requested assistance may include but is not limited to data support for questions regarding FQHC/RHC claims data and reports and the submission of claims data files to the State and/or its vendors.

- Be financially responsible for all claims with dates of service through the day of termination or expiration of the Contract, including those submitted within established time limits after the day of termination or expiration of the Contract.

- Be responsible for submitting encounter data to the State for all claims incurred prior to the contract expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after termination or expiration of the Contract.

- Be responsible for submitting all performance data with a due date following the termination or expiration of the Contract, but covering a reporting period prior to termination or expiration of the Contract, including but not limited to CAHPS, HEDIS, Reimbursement for FQHC and RHC Services and the Capitation Rate Calculation Sheet.

- Be responsible for resolving member grievances and appeals with respect to claims with dates of service prior to the day of contract expiration, including grievances and appeals filed on or after the day of Contract termination or expiration but with dates of service prior to the day of Contract termination or expiration.

- Be financially responsible for inpatient services for patients hospitalized on or before the day of Contract termination or expiration through the date of discharge, including the DRG payment and any outlier payments.

- Be financially responsible for services rendered through the day of termination or expiration of the Contract, for which payment is denied by the Contractor and subsequently approved upon appeal by the provider.

- Be financially responsible for member appeals of adverse decisions rendered by the Contractor concerning treatment of services requested prior to termination or expiration of the Contract which are subsequently upheld on behalf of the member after an appeal proceeding or after a FSSA Fair Hearing.

- Arrange for the orderly transfer of patient care and patient records to those providers who will assume care for the member. For those members in a course of treatment for which a change of providers could be harmful, the Contractor

shall continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged. The Contractor shall transfer all applicable clinical information on file, including but not limited to approved and outstanding prior authorization requests and a list of members in case or care management, to the State and/or the successor MCE at least fourteen (14) calendar days prior to the day of termination or expiration of the Contract. A final file shall be provided within five (5) business days of the termination or expiration of the Contract.

Notify all members about the Contract termination and the process by which members will continue to make POWER Account contribution payment, and receive medical care, at least sixty (60) calendar days in advance of the effective date of termination or Contract expiration. For its HIP members, the Contractor shall also explain how they will have access to POWER Account funds. The Contractor will be responsible for all expenses associated with member notification. OMPP shall approve all member notification materials in advance of distribution.

- Notify all providers about the Contract termination and the process by which members will continue to receive medical care, at least sixty (60) calendar days in advance of the effective day of termination or expiration of the Contract. The Contractor will be responsible for all expenses associated with provider notification. OMPP shall approve all provider notification materials in advance of distribution.

- Report any capitation or other overpayments made by the State to the Contractor within thirty (30) calendar days of discovery and cooperate with investigations by the State or its subcontractors into possible overpayments made during the contract term. The Contractor shall return any capitation or other overpayments, including those discovered after contract expiration, to the State within fourteen (14) calendar days of reporting the overpayment to the State.

- Coordinate the continuation of care for members who are undergoing treatment for an acute condition.

- Be responsible to submit the HEDIS Auditor Report listed in Section 12, 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 shall have the right to withhold some or all retroactive capitation adjustment payments due and owing to the Contract in the event the Contractor fails to comply with the responsibilities set forth in this section, including its responsibilities related to data submission and support.

EXHIBIT 2.H

HEALTHY INDIANA PLAN SCOPE OF WORK

14.4 Damages

The Contractor acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State, which may not be adequately compensable in damages. The Contractor acknowledges that the State has incurred substantial expenses in connection with the preparation and entry into the Contract, including expenses relating to training staff, data collection and processing, actuarial determination of capitation rates, and ongoing changes to the State's and its fiscal agent's management information systems. The Contractor further acknowledges and agrees that in the event the Contract is terminated prior to the end of the initial term or any renewal term, due to the actions of the Contractor or due to the Contractor's failure to fully comply with the terms and conditions of the Contract, the State will incur substantial additional expense in processing the disenrollment of all members and the related MIS changes, in effecting staffing changes, in procuring alternative health care arrangements for members, and in other areas unknown to the State at this time. The Contractor accordingly agrees that the State may, in such event, seek and obtain actual damages.

The remedies available to the State under this Agreement include but are not limited to:

- Obtaining payment under the performance bond or other arrangement set forth in Section 13.2;

- Assessing actual damages measured by the cost to the State to transition members to other providers and/or another Contractor. This includes, but is not limited to, payments the State may make to other contractors to perform work related to the transition.

Payment of the performance bond or other arrangement established under Section 13.2 is due within ten (10) calendar days of the date of termination. Payment of liquidated damages is due within thirty (30) calendar days from the date of termination. Payment of actual damages is due within ten (10) calendar days of the Contractor's receipt of the State's demand for payment.

14.5 Assignment of Terminating Contractor's Membership and Responsibilities

If the Contract is terminated for any reason, the State may assign the Contractor's membership and responsibilities to one or more other MCEs who also provide services to and HIP populations, subject to consent by the MCE that would gain the member enrollment.

In the event that OMPP 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.

14.6 Refunds of Advanced Payments

The Contractor shall, within thirty (30) calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the Contract.

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14.7 Termination Claims

If the Contract is terminated under this section, the Contractor shall be entitled to be paid a prorated capitation amount, determined by the State based on available information, for the month in which notice of termination was received for the service days prior to the effective date of termination. The Contractor will have the right of appeal, as stated under the subsection on Disputes in the Contract, of any such determination. The Contractor will not be entitled to payment of any services performed after the effective date of termination.

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EXHIBIT 4.H

HEALTHY INDIANA PLAN CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Except as defined below or where the context requires otherwise, all capitalized terms shall have the meanings ascribed to them in the Contract.

Note that previous versions of this Exhibit that relate specifically to previous years (calendar years 2017, 2018, 2019, and 2020) 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 HIP program. To assess attainment of this goal, the State monitors certain quality and performance standards, and holds the Contractor accountable for being in compliance with Contract terms. FSSA accomplishes this by working collaboratively with the Contractor to maintain and improve programs, and not to impair Contractor stability.

In the event that the Contractor and/or its subcontractors/vendors fails to meet performance requirements or reporting standards set forth in the Contract or other standards established by the State, the State will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies discussed below or in this Contract. The State will provide written notice of non-compliance to the Contractor within sixty (60) calendar days of the State's discovery of such non-compliance.

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.

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HEALTHY INDIANA PLAN CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

- Suspending Auto-assignment: FSSA may suspend auto-assignment of members to the Contractor. The State may suspend all auto-assignment or may selectively suspend auto-assignment for a region or county. The State will notify the Contractor in writing of its intent to suspend auto-assignment at least ten (10) business days prior to the first day of the suspension period. The suspension period may be for any length of time specified by the State. The State will base the duration of the suspension upon the nature and severity of the default and the Contractor's ability to cure the default.

- Assigning the Contractor's Membership and Responsibilities to Another Contractor: The State may assign the Contractor's membership and responsibilities to one (1) or more other Contractors that also provide services to the Healthy Indiana Plan population, subject to consent by the Contractor that would gain that responsibility. The State must notify the Contractor in writing of its intent to transfer members and responsibility for those members to another Contractor at least ten (10) business days prior to transferring any members.

- 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 its actual or liquidated pursuant to this Contract, its actual damages, and/or penalties as expressly permitted under 42 USC Chapter Seven, Subchapter XIX, Section 1396u-2 (e).

It is agreed that in the event of a failure to meet specified performance or reporting requirements subject to liquidated damages, it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the State will sustain in the event of, and by reason of, such failure; and it is therefore agreed that the Contractor will pay the State for such failures according to the following subsections. No punitive intention is inherent in the following liquidated damages provisions.

FSSA may impose remedies resulting from failure of the Contractor to provide the requested services depending on the nature, severity, and duration of the deficiency. In most cases, liquidated damages will be assessed based on this Exhibit. Should FSSA choose not to assess damages for an initial infraction or deficiency, it reserves the right to require corrective action or assess damages at any point in the future.

The State shall notify Contractor of liquidated damages due and Contractor shall pay the State the full amount of liquidated damages due within ten (10) business days of receipt of the State's notice. The State may, in its sole discretion, elect at any time to offset any amount of liquidated damages due against capitation payments otherwise due Contractor pursuant to the Contract.

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HEALTHY INDIANA PLAN CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

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.

4. Non-compliance with Reporting Requirements.

The Healthy Indiana Plan MCE Reporting Manual, distributed following the Contract award and periodically thereafter, details the required formats, templates and submission instructions for the reports listed in the Contract. FSSA may change the frequency of required reports, or may require additional reports, at FSSA's discretion. The Contractor will be given at least thirty (30) calendar days' notice of any change to reporting requirements.

If the Contractor's non-compliance with the reporting requirements impacts the State's ability to monitor the Contractor's solvency, and the Contractor's financial position requires the State to transfer members to another Contractor, the State will require the Contractor to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement Contractor as a result of member transfer. In addition the Contractor must pay any costs the State incurs to accomplish the transfer of members. Further, FSSA will withhold all capitation payments or require corrective action until the Contractor provides satisfactory financial data.

5. Priority Performance and Reporting Requirements.

FSSA assigns a high priority to a number of MCE reports. The following is an example list of reports (collectively referred to herein as "Priority Reports"):

No	Title
	Systems and Claims Reports
0101	Claims Adjudication Summary
0102	Encounters Summary
0103	Claims Denial Reasons
0104	Paid Abortion Claims Summary
	Member Services Reports
0201	Member Helpline Performance
0202	Member Grievances and Appeals
0204	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Summary
	Provider Services Reports
0301	Provider Helpline Performance
0303	Provider Claims Disputes
	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
	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

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HEALTHY INDIANA PLAN CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

No	Title
1104	Annual Program Integrity Plan Report
	Utilization Management Reports
0514	Care/Complex Case Management Reports
0512	Health Needs Screening Report
0704	Medically Frail Member Identification
0509	Weeks of Pregnancy
	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	Key Staff Vacancy Report
0801	Vendor Contact Sheet
	POWER Account Reports
0707	Aggregate POWER Account Contribution Detail
0708	Aggregate POWER Account Contribution Refund Detail
	Pharmacy Reports
0505	Pharmacy Services Utilization Reports
0506	Pharmacy Audit Report
	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 in a timely, complete and accurate manner (other than the HEDIS and CAHPS reports), Contractor shall pay liquidated damages of four thousand, six hundred and fifty dollars ($4,650) 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 four thousand, nine hundred and fifty dollars ($4,950) for each business day the report is not submitted in a timely, complete, and accurate manner.

Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate reports required under the Contract.

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 Healthy Indiana Plan MCE 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

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the Healthy Indiana Plan MCE 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 Report (previously CRCS).

FSSA recognizes the importance of monitoring Contractor performance throughout the calendar year, and Contractor shall be required to submit quarterly Encounter Data Quality reports to FSSA in a timely, complete and accurate manner, for the HIP program in accordance with the reporting manual. Each quarterly report must include year-to-date information and must be verified to a degree of at least ninety-eight percent (98%) completeness for all claims (i.e., an incompleteness rate of no more than 2.0%). The Healthy Indiana Plan Reporting Manual details the requirements for submission of Encounter Data Quality reports.

FSSA will use Contractor's encounter data, or other method of data completion verification deemed reasonable by FSSA, to verify the completeness of the Encounter Data Quality report in comparison to Contractor's encounter claims. FSSA reserves the right to change the method of data completion verification upon reasonable advance notice to the Contractor.

Encounter Data Quality reports are considered Priority Reports. To the extent Encounter Data Quality submissions or underlying encounter data is used in a public report, it must be received by stated deadline in order to be published.

If, during any quarter after the first year of the Contract, Contractor fails to submit Encounter Data Quality reports to FSSA in a timely, complete and accurate manner, and does not meet the ninety-eight percent (98%) completeness threshold, the Contractor shall pay liquidated damages of forty-nine thousand, two hundred dollars ($49,200), per quarter.

Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate Encounter Data Quality reports required under the Contract.

8. Non-compliance with Shadow/Encounter Claims Submission Requirements.

Payment of liquidated damages as outlined below does not relieve Contractor of its responsibility to provide complete and accurate shadow/encounter claims required under the Contract.

a. Weekly Batch Submission.

The Contractor must submit at least one (1) batch of shadow claims, in the format specified by the State, before 5 p.m. on Wednesday of each week, for both institutional and professional claims, in accordance with the terms of the Contract and Scope of Work. If, during any calendar month, Contractor fails to submit all shadow/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 shadow claims batch submission, Contractor must achieve no less than a ninety-eight percent (98%) compliance rate with pre-cycle edits. The State will assess pre-cycle edit compliance based upon the average compliance rate of the weekly shadow 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-eight percent (98%), Contractor shall pay liquidated damages in the

amount of four thousand, eight hundred and fifty dollars ($4,850) for each deficient shadow claim type. Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate shadow claims required under the Contract.

c. Prescription Drug Rebate File.

Contractor shall comply with the required layouts for submitting pharmacy claim extracts used to support federal drug rebate invoicing and collection. The frequency of file submissions and the content of the files supporting drug rebate invoicing and collection are defined by FSSA and pertain to all pharmacy claim transactions and medical claim transactions that contain physician administered drugs as set forth in The Scope of Work. Contractor shall provide this reporting to FSSA in the manner and timeframe prescribed by FSSA, including, but not limited to, through a rebate file to the State or its designee. For any instance in which the Contractor fails to provide required files for drug rebate purposes in a timely, accurate, or complete manner, the Contractor shall be responsible for interest, based on the interest calculation for late rebate payments methodology published by CMS, on delayed rebate money owed to the State. For example, if the Contractor fails to meet the FSSA established deadline for submission of the claim extracts and/or rebate file and the drug rebate contractor completes the quarterly drug rebate invoicing process without the Contractor's claim information for the invoicing quarter, the Contractor shall reimburse the State for interest on the rebate amount later calculated by the drug rebate contractor, for the period of delay in collecting the rebate amount. Such reimbursement shall be due within thirty (30) days of presentation of the interest calculation.

9. Network Access.

If FSSA determines that the Contractor has not met the network access standards established in the Contract, FSSA shall require submission of a Corrective Action Plan to FSSA within ten (10) business days following imposition of sanctions. Determination of failure to meet network access standards shall be made following a review of the Contractor's Network Geographic Access Assessment Report. The frequency of required report submission shall be outlined in the Healthy Indiana Plan MCE Reporting Manual. Contractor will pay liquidated damages in the amount of five thousand, two hundred and fifty dollars ($5,250) for each reporting period that the Contractor fails to meet the network access standards. Upon discovery of noncompliance, the Contractor shall be required to submit monthly Network Geographic Access Assessment Reports until compliance is demonstrated for sixty (60) consecutive days. FSSA may also require the Contractor to maintain an open network for the provider type for which the Contractor's network is non-compliant. Further, should Contractor be out of compliance for three (3) consecutive months as a result of failure to meet network access standards, FSSA shall immediately suspend auto-enrollment of members with the Contractor, until such time as Contractor successfully demonstrates compliance with the network access standards.

10. 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 7.1 of the Scope of Work and 42 CFR 438.104, Contractor shall pay liquidated damages of nine hundred and fifty dollars ($950) 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.

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11. 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 the Scope of Work and 42 CFR 438.104, Contractor shall pay liquidated damages of one thousand one hundred dollars ($1,100) 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 material that have not been approved by FSSA or those that have been approved by FSSA that Contractor identifies as containing inaccurate, false or misleading information. For further illustration, a violation will be determined to exist if the Contractor distributes any member or provider communication, including member or provider letters, bulletins, alerts, press releases or other press communications, bulletins and forms, without prior approval by FSSA. For purposes of this Section, provider communications are limited to provider communications related to the HIP programs.

12. Claims Payment.

If Contractor fails to pay or deny ninety-eight percent (98%) or more of any type of clean claims within the required timeframe, Contractor shall pay liquidated damages in the amount of five thousand, seven hundred dollars ($5,700) for each deficient claims type. For the purposes of this section, there are six claims types: professional paper claims, professional electronic claims, facility paper claims, facility electronic claims, pharmacy paper claims, and pharmacy electronic claims. This section includes payment of dental claims.

13. Readiness Review.

If Contractor fails to satisfactorily pass the readiness review at least thirty (30) calendar days prior to scheduled member enrollment (or other deadline as may be established at the sole discretion of the State), the State may delay member enrollment and/or may require other remedies (including, but not limited to Contract termination), and Contractor shall be responsible for all costs incurred by the State as a result of such delay.

In addition, for each business day that Contractor fails to submit readiness review responses beyond their expected due date, Contractor shall pay liquidated damages in the amount of five thousand, four hundred, and fifty dollars ($5,450). Damages will be assessed each time the requirement is not met. In each instance that Contractor shall pay liquidated damages in the amount of three thousand, fifty dollars ($3,050).

14. Member/Provider Helpline and Website Services.

There are eleven (11) separate measures that will equally apply to the Healthy Indiana Plan Member/Provider Helpline and Website Metrics and the Pharmacy Helpline and Website Metrics Reports. For each instance in which the Contractor has failed to meet a metric for a given quarter, the Contractor shall pay liquidated damages in the amount of one thousand, three hundred and fifty dollars ($1,350) per quarter of non-compliance for each metric.

Helpline and Website Metrics: The eleven (11) metrics are:

i. For any calendar month, at least ninety-seven percent (97%) of all phone calls to the Helpline must reach the call center menu within thirty (30) seconds or the prevailing benchmark established by the NCQA.

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

iv. For any calendar month, the busy rate associated with the Helpline shall not exceed zero percent (0%).

v. Hold time shall not exceed one minute in any instance, or thirty (30) seconds, on average.

vi. For any calendar month, the lost call (abandonment) rate associated with the Helpline shall not exceed five percent (5%).

vii. 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.

viii. 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.

ix. Contractor's Helpline at all times must be properly equipped to accept calls including, without limitation, calls from members with limited English proficiency and calls from members who are deaf, hearing impaired or have other special needs.

x. For any calendar month, eighty-five percent (85%) of all calls to the Helpline must be resolved during the initial call.

xi. Contractor must make pertinent information available to members and providers through an Internet website in an FSSA-approved format in accordance with the terms of the Contract. The website must be available for access by members no less than twenty three and one-half (23.5) hours per day, on average.

15. Prior Authorization.

Contractor must respond to requests for authorization of services in the format and within the timeframes set forth in the Contract. For each quarter in which the Contractor fails to adjudicate ninety-seven per cent (97%) or more of prior authorization requests within the required timeframes, Contractor shall pay liquidated damages in the amount of five thousand, seven hundred and fifty dollars ($5,750).

16. Member Grievances.

Contractor must resolve one hundred percent (100%) of member grievances within thirty (30) calendar days of receipt of the grievance. For each quarter in which in which Contractor fails to provide and communicate a timely resolution on one hundred (100%) of member grievances, Contractor shall pay liquidated damages in the amount of three thousand dollars ($3,000).

17. Member Appeals.

Contractor must resolve one hundred percent (100%) of member appeals within thirty (30) calendar days of receipt of the appeal. For each quarter in which in which Contractor fails to

provide and communicate a timely resolution on one hundred percent (100%) of member appeals, Contractor shall pay liquidated damages in the amount of two thousand, two hundred dollars ($2,200). 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 fifty dollars ($1,050).

18. Complaints and Internet Quorum Inquiries.

The Contractor must resolve complaints and Internet Quorum (IQ) inquiries to FSSA's satisfaction, within the timeframes set forth by FSSA. Unless an alternative deadline is identified by FSSA for a specific IQ inquiry, IQ inquiries must be resolved in no more than five (5) business days. The Contractor may request additional time to respond, but FSSA is under no obligation to grant extensions. For each instance in which the Contractor fails to provide a timely or accurate response to complaints or IQ inquiries within the timeframes set forth by FSSA, Contractor shall pay liquidated damages in the amount of three hundred dollars ($300).

19. POWER Account Performance.

Contractor must provide POWER Account services within the timeframes specified below. For each instance in which Contractor fails to meet the requirements of this section, Contractor shall pay liquidated damages in the amount of one thousand, six hundred and fifty dollars ($1,650).

a. Funds deposited by the State must be credited to a member's account within two (2) calendar days.
b. Member contributions via direct deposit or payroll withholding must be credited to the member's account within two (2) calendar days of deposit.
c. Member contributions via mailed paper check must be credited to the member's account within five (5) calendar days after the check has cleared. Member contributions via money order must be credited to the member's account within five (5) calendar days of payment receipt.
d. In the event that a member loses eligibility, the Contractor shall refund the member the balance of their POWER account within sixty (60) calendar days of the date the member loses eligibility.
e. In the event that a member loses eligibility, the Contractor shall refund the State the balance of their POWER account within one hundred twenty (120) calendar days of the date the member loses eligibility.
f. POWER Account Reconciliation Files (PRFs) must be submitted in a timely and accurate manner for all members (including those with zero contributions), based upon the timeframes specified by the State.

20. Medically Frail Identification.

The Contractor shall be subject to an audit of Healthy Indiana Plan members designated as medically frail. The State will audit a minimum of five percent (5%) of all its members identified by the Contractor as medically frail. If the results of the audit indicate that inappropriate identifications have been made in greater than ten percent (10%) of the audited cases the Contractor shall pay liquidated damages as follows:

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- If the State's auditor finds that inappropriate referrals have been made in greater than ten percent (10%) and less than or equal to twenty percent (20%) of audited cases, the Contractor shall pay liquidated damages in the amount of one percent (1%) of the total medically frail capitation (including administrative portion) received during the audit period.

- If the State's auditor finds that inappropriate referrals have been made in greater than twenty percent (20%) or more of audited cases, the Contractor shall pay liquidated damages in the amount of two percent (2%) of the total medically frail capitation (including administrative portion) received during the audit period.

Prior to imposing sanctions, Contractor, at its sole expense, shall have the right to dispute the State's auditor findings. Contractor may present to FSSA documentation used to determine member met the criteria for medically frailty. Sanctions will not be imposed if member met the medically frail criteria at the time of the referral. Information after the date of referral cannot be grounds for imposing sanctions.

The Contractor shall refund the State the difference between the applicable capitation rate and the capitation rate actually received as a result of the inappropriate medically frail designation.

21. Plan Solvency.

If Contractor fails to meet solvency performance standards set forth below and as may be amended by the State, Contractor shall be subject to corrective actions as set forth in the Contract, including but not limited to Contract termination.

a. On a quarterly basis, current ratio (assets to liability) shall be greater than or equal to one (1).
b. On a quarterly basis, the number of day's cash on hand shall not be fewer than sixty (60) business days. Contractors may not count POWER Account balances as cash on hand. FSSA reserves the right to adjust the required number of days of cash on hand based on historical Contractor performance and the ability of the Contractor to demonstrate solvency.
c. On a quarterly basis, days in unpaid claims shall not be greater than sixty-five (65) business days.
d. On a quarterly basis, days in claims receivables shall not be greater than thirty (30) business days.
e. On a quarterly basis, equity (net worth) shall be maintained at or above $50 per member.

22. 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 shall 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 Plan is required to provide, under law or under its Contract with the State, to a member;

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- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Healthy Indiana Plan 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.

23. Other Non-Performance.

If Contractor fails to meet the other performance standards set forth in the Contract, Contractor shall be subject to corrective actions as set forth in the Contract.

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B. Pay for Outcomes Program

1. Program Establishment and Eligibility.

FSSA has established a pay for outcomes program under which Contractor may receive additional compensation if certain conditions are met. The state encourages plans to share earned incentive payments with members and providers. The compensation under the pay for outcomes program is subject to Contractor's complete and timely satisfaction of its obligations under the Contract. This includes but is not limited to timely submission of the Contractor's CAHPS and HEDIS Reports for the measurement year and the Certified HEDIS Compliance Auditor's attestation, as well as timely submission of the 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:

a. FSSA has suspended, in whole or in part, capitation payments or enrollment to the Contractor;
b. FSSA has assigned, in whole or in part, the membership and responsibilities of Contractor to another participating managed care plan contractor;
c. FSSA has assumed or appointed temporary management with respect to the Contractor;
d. The Contract has been terminated;
e. The Contractor has, in the determination of the Director of the Office of Medicaid Policy and Planning, failed to execute a smooth transition at the end of the Contract term, including failure to comply with the MCE responsibilities set forth in the Scope of Work; or
f. Pursuant to the Contract, including without limitation this Exhibit, FSSA has required a corrective action plan or assessed liquidated damages against Contractor in relation to its performance under the Contract during the measurement year.

FSSA may, at its option, reinstate Contractor's eligibility for participation in the pay for outcomes program once Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract, and FSSA has satisfactory assurances of acceptable future performance.

2. Incentive Payment Potential.

a. Withhold.

During each measurement year, FSSA will withhold a portion of the approved capitation payments from Contractor as follows:

Year 1, 2017 – one point eight two percent (1.82%)
Year 2, 2018 – two point zero five percent (2.05%)
Year 3, 2019 – two point zero five percent (2.05%)
Year 4, 2020 – two point zero five percent (2.05%)
Year 5, 2021 – two point zero five percent (2.05%)
Year 6, 2022 – four point five six percent (4.56%)

Capitation payments will be withheld separately for the Contractor's HIP line of business. Contractor shall be eligible to receive some or all of the withheld funds based on Contractor's performance in the areas outlined in Section B.4.a of this Exhibit. Withhold payments will be calculated as set forth in Section B.4.a of this Exhibit. The State reserves the right to adjust performance measures and targets in future Contract years.

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b. Additional Maternity Payments and Incentives.

FSSA will reimburse Contractor $60 for each Notification of Pregnancy (NOP) form completed and submitted to FSSA in accordance with the standards set forth by the State. This payment will be made on a monthly basis with capitation payments. The Contractor must distribute the entire $60 payment to the physician that completed the NOP form on behalf of the pregnant member.

For each NOP form completed and submitted to FSSA in accordance with the standards set forth by the State, FSSA shall deposit $40 in a birth outcomes bonus pool. Contractors may be eligible to receive a bonus payment in the amount of some or all of the birth outcomes bonus pool funds based on its achievement of a high rate of ongoing prenatal care. The bonus payment will be calculated as set forth in Section B.4.c.

NOP forms must be submitted in the form and manner set forth by FSSA. Reimbursement is limited to one NOP form per member, per pregnancy, regardless of whether the member receives pregnancy services through the HIP program. In order to qualify for reimbursement, the NOP form must meet standards set forth by FSSA.

3. Outcome Measures and Incentive Payment Structure.

The outcome measures, targets, and incentive payment opportunities are outlined below. Outcome measures and targets are based on priority areas established by FSSA and data available in year one (1) of the contract. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. Outcome measures and priorities may change with the findings of the annual External Quality Review. Note that if a performance measure is retired during the course of a year, the State, at its sole discretion and in consultation with the Contractor, may replace the performance measure for that performance period. The performance measures and targets applicable during subsequent years of the Contract will be established annually by FSSA and reflected in an amendment to the Contract.

4. Performance Measures and Incentive Payment Structure.

Contractor performance shall be calculated based on care delivered during the calendar year. Incentive payments after calendar year 2017, for any measure, may be conditioned upon Contractor substantially maintaining or improving Contractor's outcome on that individual measure from the previous year.

Measures will be paid based on custom specifications and performance as determined by FSSA. Contractor shall submit information to FSSA, in the format and detail specified by FSSA, with respect to each performance measure set forth below. Any data received after the required submission date will not be eligible for an incentive payment.

The amount of performance withhold at risk for pay for outcomes measures will be established for the first year of the contract and reviewed annually thereafter. The amounts set for 2017 and any changes year over year will be at the sole discretion of the State. Annual adjustment to withhold percentages may occur to reflect OMPP priorities.

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For each performance measure, it is anticipated that there will be three (3) tiers of withhold available to be earned. Rates will be set based upon the priority measure for the Contractor to earn fifty percent (50%), seventy-five percent (75%), or one hundred percent (100%) of the amount of the Performance Withhold at risk. Contractor is eligible to receive its incentive payment based on measurement year rate regardless of prior year performance.

a. Incentive Payments – Withholds – HIP

The following incentives are payable in the form of release of funds withheld. For purposes of this subsection only, the amount withheld shall be referred to as the "Performance Withhold." The amount of the Performance Withhold at risk varies by measure. The amounts of Performance Withhold at risk listed below are rounded to the nearest hundredth decimal point.

i. Adult preventive care.

Percentage of members twenty (20) years and older who had a preventive care visit. HEDIS measure (HEDIS AAP) using administrative data.

Amount of Performance Withhold at risk: 15%

If Contractor's 2021 measurement year rate is at or above the 25th percentile and below the 50th percentile of NCQA 2022 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 2021 measurement year rate is at or above the 50th percentile and below the 75th percentile of NCQA 2022 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 2021 measurement year rate is at or above the 75th percentile of NCQA 2022 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

*ii. Completion of Health Needs Screenings for New Members***.**

Administrative reporting for completion of health needs screenings defined in the reporting template as "% Screened (all except Terminated)." It is the calculation of the percentage of newly enrolled MCE members, net of terminated members that have had a health needs screening completed within 90 days.

Amount of Performance Withhold at risk: 20%

If Contractor's 2021 measurement year rate is at or above 60% screened and below 65% screened, Contractor is eligible to receive an incentive payment equal to twenty five (25%) of the amount of the Performance Withhold at risk.

If Contractor's 2021 measurement year rate is at or above 65% screened and below 70% screened, Contractor is eligible to receive an incentive payment equal to fifty (50%) of the amount of the Performance Withhold at risk.

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If Contractor's 2021 measurement year rate is at or above 70% screened, Contractor is eligible to receive an incentive payment equal to one hundred (100%) of the amount of the Performance Withhold at risk.

iii. *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: 10%

If Contractor's 2021 measurement year rate is at or above the 25th percentile and below the 50th percentile of NCQA 2022 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 2021 measurement year rate is at or above the 50th percentile and below the 75th percentile of NCQA 2022 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 2021 measurement year rate is at or above the 75th percentile of NCQA 2022 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

iv. *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: 10%

If Contractor's 2021 measurement year rate is at or above the 25th percentile and below the 50th percentile of NCQA 2022 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 2021 measurement year rate is at or above the 50th percentile and below the 75thth percentile of NCQA 2022 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 2021 measurement year rate is at or above the 75th percentile of NCQA 2022 Quality Compass, Contractor is eligible to receive an incentive

payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

v. Post-partum visits.

Percentage of deliveries that had a postpartum visit on or between seven (7) and eighty-four (84) days after delivery. (Includes deliveries between Nov 6th of the year prior to the measurement year and Nov 5th of the measurement year.) HEDIS measure (HEDIS PPC) using hybrid data.

Amount of Performance Withhold at risk: 15%

If Contractor's 2021 measurement year rate is at or above the 25th percentile of NCQA 2022 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 2021 measurement year rate is at or above the 50th percentile of NCQA 2022 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 2021 measurement year rate is at or above the 75th percentile of NCQA 2022 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. Timeliness of Ongoing Prenatal Care.

Percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within forty-two (42) days of enrollment in the organization. HEDIS measure (HEDIS PPC) using hybrid data.

Amount of Performance Withhold at risk: 15%

If Contractor's 2021 measurement year rate is at or above the 10th percentile of NCQA 2022 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 2021 measurement year rate is at or above the 25th percentile of NCQA 2022 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 2021 measurement year rate is at or above the 50th percentile of NCQA 2022 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred (100%) of the amount of the Performance Withhold at risk.

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vii. Prenatal Depression Screening and Follow-Up (PND-E)

The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. HEDIS measure (PND-E) using hybrid data.

Amount of Performance Withhold at risk: 15%

If the Contractor timely and accurately reports this measure for the 2021 measurement year, in accordance with State expectations, the Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

b. Auto-Assignment Incentive

Effective at the start of this contract, and on a state fiscal year basis annually thereafter, the State shall adjust the auto-assignment methodology rotation based on Contractor's relative percent of the total amount of the Performance Withhold at risk earned in the previous complete calendar year. The State reserves the right to consider factors such as Contractor performance on clinical quality outcomes as reported through HEDIS data, enrollee satisfaction as delineated through the CAHPS survey results, network access and other outcome measures in adjustment of the auto-assignment methodology.

The Contractor who receives the highest percent of the amount of the Performance Withhold at risk will receive a higher percentage of all auto-assigned members in the subsequent calendar year. The remaining Contractors will receive lower proportionate shares of all auto-assigned members in the subsequent calendar year.

In the event more than one MCE achieves the same percentage of the total amount of the Performance Withhold at risk, the total percentage of auto-assignment members available to each based on their relative performance as set forth above will be divided between the tied MCEs.

c. Incentive Payments – Bonuses.

Percentage of maternity discharges in 2021, who make connection with the Indiana Tobacco Quitline. The following incentives are payable in the form of a bonus. The bonus payment will be calculated as set forth below.

i. The Contractor is eligible to receive 50% of the percent of the funds deposited in the birth outcomes bonus pool set forth in section B.2.b of the 2021 contract if 1.5% of their maternity discharges for 2021 are referred to the Indiana Tobacco Quitline and those members make at least 1 contact with the Quitline as reported on the OMPP monthly Indiana Tobacco Quitline report.

ii. The Contractor is eligible to receive 75% of the percent of the funds deposited in the birth outcomes bonus pool set forth in Section B.2.b of the 2021 contract if 3.0% of their maternity discharges for 2021 are referred to the Indiana Tobacco Quitline and those members make at least 1 contact with the Quitline as reported on the OMPP monthly Indiana Tobacco Quitline report.

iii. The Contractor is eligible to receive 100% of the percent of the funds deposited in the birth outcomes bonus pool set forth in section B.2.b of the 2021 contract if 5.0% of their maternity discharges for 2021 are referred to the Indiana Tobacco Quitline and

those members make at least 1 contact with the Quitline as reported on the OMPP monthly Indiana Tobacco Quitline report.

If MCE has 1,000 maternity discharges in 2021 they would need to have 15 connections with the Quitline for 50% of the bonus pool, 30 connections for 75% and 50 connections for 100%.

5. Timing of Payments.

a. Performance Outcomes and Targets.

FSSA will make its best efforts to distribute a report identifying Contractor's performance for the 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 Sections B.4 and B.5. FSSA will make its best efforts to distribute payment to Contractor, subject to Section B.8 below, by December 31 of each year.

b. NOP Forms.

NOP payments of $60 will be made with capitation payments. An additional $40 will be held until the performance for the ongoing prenatal care frequency bonus measure is determined. The State will distribute bonus monies according to the Section B.4.c above.

6. Conditions to Incentive Payments.

FSSA will not have any obligation to distribute the Contractor's incentive payment to Contractor if FSSA has made a determination that Contractor is not eligible to participate in the pay for performance program, as described in Section B.1 above. The State encourages plans to share earned incentive payments with member and providers.

7. Disposition of Undistributed Incentive Payment Funds.

In the event the maximum amount of the incentive payment funds available to all managed care plan contractors is not earned and distributed based on the performance of Contractor and/or other managed care plan contractors, FSSA will retain the difference (hereinafter referred to as the "undistributed incentive payment funds"). The undistributed incentive payment funds, which may include unearned withhold funds forfeited by other managed care plan contractors, may be available to Contractor to fund all or a portion of quality improvement initiatives proposed by Contractor, subject to the conditions set forth by OMPP for priorities identified in the OMPP Quality Strategy Plan. Such quality improvement initiatives may include, but are not limited to, healthcare IT initiatives (such as but not limited to incentives for provider adoption of electronic health records, e-prescribing and/or data sharing with the Indiana Health Information Exchange or other regional health information exchanges); cost and quality transparency initiatives; number of provider and member complaints handled; overall HEDIS scores; PMP access; behavioral health and physical health integration initiatives; timeliness of claims payment; and clinical initiatives.

The Director of the Office of Medicaid Policy and Planning must approve requests for any initiatives proposed to earn undistributed incentive payments funds.

FSSA has full discretion to determine whether and the extent to which any such distributions will be made and the FSSA may choose not to award undistributed incentive payments funds.

EXHIBIT 4.H

HEALTHY INDIANA PLAN CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

8. Non-Financial Incentives.

In addition to the potential to earn incentive payments based on performance in the identified areas, FSSA may establish other means to incent performance improvement.

FSSA retains the right to publicly report Contractor performance. Information which may be provided in public reports includes but is not limited to Contractor's audited HEDIS report, Contractor's Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, and information based on Encounter Data Quality submission or underlying encounter data submitted by Contractor. FSSA intends to distribute information on key performance indicators to participating managed care plan contractors and the public on a regular basis, identifying Contractor's performance, and comparing that performance to other managed care plan contractors, standards set by FSSA and/or external benchmarks or industry standards. FSSA may recognize managed care plan contractors that attain superior performance and/or improvement by publicizing their achievements. For example, FSSA may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. To the extent data is used in a public report, it must be received by stated deadline in order to be published.

In year two (2) of the Contract, FSSA intends to include Contractor quality and performance indicators on materials distributed to potential members to facilitate MCE selection. The State reserves the right to develop a rating system advertising Contractor performance on areas such as consumer satisfaction, network access and quality improvement.

Following the initial year of the Contract, after which sufficient quality data is anticipated to be available, the State seeks to reward high performing MCEs through the auto-assignment logic. For example, in developing the auto-assignment methodology, the State reserves the right to consider factors such as Contractor performance on clinical quality outcomes as reported through HEDIS data, enrollee satisfaction as delineated through the CAHPS survey results, network access and other outcome measures.

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EXHIBIT 6.D

HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

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HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

HIP Program Description & Covered Benefits

1. Overview of the Program

Medicaid is a federal-and state-funded health care program providing reimbursement for reasonable and necessary medical care for persons meeting eligibility requirements. The Indiana Family and Social Services Administration (FSSA) authorized by federally approved 1115 waiver, administers the Healthy Indiana Plan (HIP) program in Indiana. More detailed information about Indiana Health Coverage Programs (IHCP) is available on the State's website at http://www.indianamedicaid.com/.

2. Eligible and Excluded Populations

The State has sole authority for determining whether individuals or families meet any of the eligibility criteria of the HIP program. The FSSA Division of Family Resources (DFR) makes eligibility determinations.

The Healthy Indiana Plan (HIP) is a Medicaid expansion for individuals 19-64 years of age with annual household income of not more than 138% of the federal poverty level (FPL), as calculated based on the Modified Adjusted Gross Income (MAGI) guidelines with 5% income disregard. All individuals eligible for HIP, with the exception of Native Americans, must enroll in managed care.

Additional eligibility criteria are set forth in IC 12-15-44.2 and 405 IAC 10-4, as may be amended. The following individuals are not eligible for HIP:

- An individual who participates in the federal Medicare program; and
- An individual who qualifies for Medicaid under another aid category, with the exception of (i) the adult group under 42 CFR 435.119; (ii) pregnant women who choose to remain in HIP during the pregnancy; (iii) parents & caretaker relatives eligible under 42 CFR 435.110; (iv) low income individuals who are at least nineteen (19) years of age and less than twenty-one (21) years of age and eligible under 42 CFR 435.222; or (v) transitional medical assistance.

3. Delivery System

Managed care entities (MCEs), which include both Indiana-licensed accident and sickness insurers and HMOs, contract with FSSA to provide covered services to HIP enrolled members. The MCEs manage care through a contracted network of PMPs, specialists, and other providers.

The State requires MCEs to initiate network development. The State will evaluate the Contractor's progress in its network development efforts prior to the start date of the Contract. FSSA reserves the right to limit the enrollment, by county, of a particular MCE, in order to ensure the members have adequate choice of plans.

4. HIP Covered Services and Benefit Package

The HIP program covers the benefits set forth below.

HIP covered benefits include physician services, behavioral health services, inpatient and outpatient care, emergency services, preventive care services, family planning services,

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hospice, pharmacy services, DME, diagnostic services and therapies, disease management and home health, as set forth in 405 IAC 10-7, as may be amended.

Table 2 provides a general list of the HIP covered services and limitations and identifies whether each service is reimbursed by the MCEs. Contract Exhibit 2, Scope of Work and HIP MCE Policies and Procedures Manual describe the benefits and services in greater detail including, but not limited to, the following:

- Services that are covered under HIP.
- Self-referral services that include but are not limited to family planning services, psychiatric services, diabetes self-management services, emergency services, urgent care, and behavioral health services.
- Medicaid services excluded from HIP are long-term institutional care and Home and Community Based waiver services.
- Non-covered services are set forth in 405 IAC 10-7.
- In accordance with 42 CFR 438.6(f)(2)(i), which sets forth compliance requirements between MCEs and FSSA, payment shall not be made for provider-preventable conditions (PPCs).

EXHIBIT 6.D

HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

TABLE 1. HEALTHY INDIANA PLAN BENEFITS

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HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Ambulatory Patient Services			
Primary Care Physician (PCP) Services Office Visit		Services include but not limited to medical and second opinion consultations.	Yes
Specialty Physician Visits		Referral physician office visit included.	Yes
Home Health Services	100 visits per year.	Services include but not limited to nursing care given or supervised by RN and nutritional counseling.	Yes
Outpatient Surgery		Includes diagnostic invasive procedures that may or may not require anesthesia.	Yes
Allergy Testing		Includes allergy procedures-administration of serum.	Yes
Chemotherapy-Outpatient		Includes therapeutic injections which are medically necessary and may not be self-administered.	Yes
IV Infusion Services			Yes
Radiation Therapy- Outpatient			Yes
Dialysis		Coverage provided for home dialysis services.	Yes
Non-Surgical Treatment Option Morbid Obesity	6 visits per calendar year for program.	Covered service for enrollment in a physician-supervised weight loss treatment program when referred by your physician.	Yes
Outpatient Services		Includes colonoscopy and pacemaker. Benefits provided are PCP, specialty, and referral for all physician services in an outpatient facility.	Yes
Clinical Trials for Cancer Treatment	Items and services that are not routine care costs or unrelated to the care method will not be covered.	The clinical trial must be approved or funded by an approved entity. Coverage provided for routine care costs that are incurred in the course of a clinical trial.	Yes
Dental- Limited Covered Services- Accident/Injury	Treatment complete within 1 year from initiation; Coverage not provided for orthodontia, dental procedures, repair of injury caused by an intrinsic force, repair of artificial teeth, dentures, or bridges and other dental services.	Injury to sound and natural teeth including teeth that have been filled capped or crowned.	Yes
Urgent Care- Walk-ins		Coverage includes after hours care.	Yes

EXHIBIT 6.D

HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Routine Foot Care	6 visits per year; Coverage not provided for supportive devices of the feet, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions and calluses.	Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases.	Yes
Voluntary Sterilization for Males			Yes
Emergency Services			
Emergency Department Services	Medical care provided outside of the U.S. is not covered.	Emergency room included.	Yes
Emergency Transportation: Ambulance/Air Ambulance		Other medically necessary ambulance transport (ambulance, medi-van or similar medical ground, air or water transport to or from the hospital or both ways and transfer from a hospital to a lower level of care) is covered when ordered by your PCP.	Yes
Hospitalization			
General Inpatient Hospital Care	Benefit does not include personal comfort items and room and board when temporary leave permitted.	Services include but not limited to intensive care unit/coronary care unit; inpatient cardiac rehabilitation; and inpatient rehabilitation therapy.	Yes
Inpatient Physician Services		Benefit includes PCP, specialty and may require referral for physician services in the hospital.	Yes
Inpatient Surgical Services	Benefit does not include personal comfort items and room and board when temporary leave permitted.	Surgical operations may include replacement of diseased tissue removed while a member.	Yes
Non-Cosmetic Reconstructive Surgery	Services begin within 1 year of the accident; Benefit does not include personal comfort items and room and board when temporary leave permitted.	Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident occurring while a member.	Yes
Mastectomy- Reconstructive Surgery	Benefit does not include personal comfort items and room and board when temporary leave permitted.		Yes

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HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Transplants		Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a member. Specialty Care Physician (SCP) provides pre-transplant evaluation. Non-experimental, non-investigational organ and other transplants are covered.	Yes
Congenital Abnormalities	Benefit does not include personal comfort items and room and board when temporary leave permitted.		Yes
Anesthesia		Includes anesthesia services and supplies	Yes
Hospice Care	Room and board services are not covered when temporary leave permitted.	Hospice care provided if terminal illness, in accordance with a treatment plan before admission to the program. Treatment plan must provide statement from physician that life expectancy is 6 months or less. Concurrent care is provided to children (19 & 20 year olds).	Yes
Medical Social Services		Assist member and family in understanding and coping with emotional and social problems affecting health status.	Yes
Dialysis			Yes
Chemotherapy			Yes
Radiation Therapy			Yes
Inpatient Cardiac Rehabilitation	90 days annual maximum.		Yes
Inpatient Rehabilitation Therapy	90 days annual maximum.	Coverage includes physical, occupational, speech and pulmonary therapy of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning.	Yes
Maternity and Newborn Care			
Maternity Care	The benefit provides for antepartum services up to 14 visits for normal pregnancies. High-risk pregnancies may allow for additional visits. Postpartum services include 2 visits within 60 days of delivery.	Coverage is provided from the State Plan and includes various obstetrical services such as antepartum and postpartum visits, laboratory and x-ray (ultrasound) services and other services.	No

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HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Maternity-Delivery		Coverage is provided from the State Plan.	No
Pregnancy Benefits			
Chiropractic Manipulations - Pregnancy Benefit	Limits equivalent to State Plan.	Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage is limited to services related to pregnancy, conditions that may complicate the pregnancy or urgent care services.	No
Non-emergency Transportation - Pregnancy Benefit		Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage is provided subject to program restrictions.	No
Medicaid Rehabilitation Option (MRO) - Pregnancy Benefit		Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. MRO services are designed to assist in the rehabilitation of the consumer‘s optimum functional ability in daily living activities.	No
Dental Services - Pregnancy Benefit	Limits equivalent to State Plan.	Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The dental benefits include State Plan equivalent benefits.	No
TMJ - Pregnancy Benefit Basic Plan		Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan.	No

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HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Adult Vision - Pregnancy Benefit Basic Plus	Limits equivalent to State Plan.	Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The dental benefits include State Plan equivalent benefits.	No
Health Education - Tobacco Dependence Treatment - Pregnancy Benefit	12-week course in smoking cessation for treatment and counseling.	Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan.	No
Mental Health and Substance Use Disorder Services including Behavioral Health Treatment			
Mental/Behavioral Health Inpatient	Benefits do not include personal comfort items and room and board when temporary leave available.	These services are not provided through institutions of mental disease (IMDs).	Yes
Mental/Behavioral Health Outpatient	Coverage does not include self-help training or other related forms of non-medical self-care.	Coverage applies to individual therapy and group therapy sessions.	Yes
Substance Abuse Inpatient Treatment	Benefit does not include services and supplies for the treatment of co-dependency or caffeine addiction, personal comfort items, and room and board when temporary leave permitted.	These services are not provided through institutions of mental disease (IMDs).	Yes
Substance Abuse Outpatient Treatment	Benefit does not include services and supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction.	Coverage includes detoxification for alcohol or other drug addiction.	Yes

EXHIBIT 6.D

HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Prescription Drugs			
Generic and Brand Name Formulary	Select drugs are carved out of the HIP capitation rates for CY 2021 (full rating period). Below is a list of the drugs that have been carved out: • 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	The formulary covers at least the same level of services as the base benchmark pharmacy benefit, including one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater. This benefit is provided through the Managed Care Entities, and the exact drugs covered under the formulary may vary by MCE. The MCE must offer additional pharmacy services for the HIP Plus and HIP State Plan Plus plans, including (i) 90 day prescription supplies; (ii) mail order pharmacy benefit; and (iii) medication therapy management (MTM) services.	Yes
Rehabilitative and Habilitative Services			
Physical Therapy, Occupational Therapy, Speech Therapy	60 (Basic Plan); 75 (Plus Plan) combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.		Yes
Durable Medical Equipment (DME)	15 month rental cap; 1 every 5 year per member- replacement; DME does not include corrective shoes, arch supports, and other non-durable supplies. Equipment not suitable for home use is a non-covered benefit.	Benefit includes but not limited to wheel chairs, crutches, respirators, traction equipment, hospital beds, monitoring devices, oxygen-breathing apparatus, and insulin pumps. Training for use of DME is also covered and applicable rental fees.	Yes

EXHIBIT 6.D

HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Prosthetics	Benefit does not include foot orthotics and devices solely for comfort or convenience.	Covered services include the purchase, replacement, or adjustment of artificial limbs when required due to a change in your physical condition or body size due to normal growth.	Yes
Corrective Appliances	Benefit does not include but not limited to artificial or prosthetic limbs, cochlear implants, or dental appliances.	Benefit includes but not limited to hemodialysis equipment, breast prostheses, back braces, artificial eyes, one pair eyeglasses due to cataract surgery, ostomy supplies, and prosthetics (all prosthetics except prosthetic limbs.)	Yes
Cardiac Rehabilitation	60 (Basic Plan); 75 (Plus Plan) combined visits annually for PT, OT, ST, and pulmonary rehabilitation.	Benefit includes services for the improvement of cardiac disease or dysfunction.	Yes
Medical Supplies	Benefit does not include non-durable supplies and/or convenience items.	Benefit includes casts, dressings, splints, and other devices used for reduction of fractures and dislocations.	Yes
Pulmonary Rehabilitation	60 (Basic Plan); 75 (Plus Plan) combined visits annually for PT, OT, ST, and cardiac rehabilitation.		Yes
Skilled Nursing Facility (SNF)	100 days per benefit period; Room and board services are not covered when temporary leave permitted.	Services include but not limited to medical social services and short term physical, speech and occupational therapies (subject to limits).	Yes
Autism Spectrum Disorder Services	60 (Basic Plan); 75 (Plus Plan) combined visits annually.	Benefit provides coverage for Asperger's syndrome and autism. Coverage for services are provided as prescribed by the treating physician in accordance with the treatment plan.	Yes
Hearing Aids	1 per member every 5 years.		Yes
Home Health: Medical Supplies, Equipment and Appliances	Benefit does not include non-durable supplies and/or convenience items.		Yes
Laboratory Services			
Lab Tests	Coverage does not include lab expenses related to physical exams when provided for employment, school, or other similar purposes.		Yes

EXHIBIT 6.D

HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
X-rays	Coverage does not include lab expenses related to physical exams when provided for employment, school, or other similar purposes.		Yes
Imaging- MRI, CT, and PET		Coverage also includes MRA and SPECT scan.	Yes
Pathology			Yes
Radiology			Yes
EKG and EEG			Yes
Preventive and Wellness Services and Chronic Disease Management			
Preventive Care Services		Physician services for wellness and preventive services include but are not limited to routine physical exam, routine total blood cholesterol screening, routine gynecological services, and routine immunizations. Includes (1) all preventive items or services that have a rating of ‘A’ or ‘B’ by the United States Preventive Task Force (USPSTF); (2) Immunizations recommended for the individuals age and health status by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); (3) for infants, children, adolescents and adults, preventive care and screenings included in the Health Resources and Services Administration’s (HRSA) Bright Futures comprehensive guidelines, and (4) preventive screenings for women as recommended by the Institute of Medicine (IOM).	No
Diabetes Self Management Training		Covered services are limited to physician authorized visits after receiving a diagnosis of diabetes; after receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management; and for re-education or refresher training.	No

EXHIBIT 6.D

HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Health Education	3 visits for classes in nutrition or tobacco dependence treatment when referred by your physician.		No
Routine Prostate Specific Antigen (PSA) Test	One test annually for an individual who is at least 50 years old or less than 50 if at high risk.		No
Pediatric Services including Oral and Vision Care			
EPSDT Benefits	EPSDT is required in the ABP for 19 and 20 year olds.	Services provided under EPSDT may include preventive and diagnostic services that are medically necessary and may need continued treatment.	Yes/No (Depends on type of service received.)
Other Covered Benefits- Plus Plan			
Dental Coverage		The dental benefits include evaluations and cleanings (2 per person per benefit year); bitewing x-rays (4 x-rays per person per benefit year); comprehensive x-rays (1 complete set every 5 years); minor restorative services, such as fillings (4 per person per benefit year); and major restorative services, such as crowns (1 per person per benefit year).	Yes
Adult Vision		The vision benefits include routine exam (1 every 2 years); eyeglasses, including frames and lenses (1 pair every 5 years if there is not a sufficient change in prescription (vision), loss, irreparable damage, or theft); frames include but not limited to plastic or metal; replacement eyeglasses (covered when medical necessity guidelines met or due to loss, theft or damage beyond repair); contact lenses (covered for medical necessity, such as facial deformity or allergy to frame prevents wearing eyeglasses); vision surgeries (covered for medical necessity); and vision training therapies (covered for medical necessity. Not all frames and lenses are covered, unless medically necessary. Members may choose to upgrade frames and lenses and pay the difference.	Yes
TMJ			Yes

EXHIBIT 6.D

HEALTHY INDIANA PLAN PROGRAM DESCRIPTIONS AND COVERED BENEFITS

Benefit	Limits	Benefit Information	Subject to POWER Account Deductible
Bariatric Surgery	Benefits do not include personal comfort items and room and board when temporary leave available.	To be eligible for this benefit the member must: (1) have morbid obesity that has persisted for at least five years duration, and Physician-supervised non-surgical medical treatment has been unsuccessful for at least 6 consecutive months; or (2) successfully achieve weight loss after participating in physician-supervised non-surgical medical treatment but has been unsuccessful at maintaining weight loss for two years [> 3 kg (6.6 lb.) weight gain].	Yes
Chiropractic Manipulations	Limited to one (1) unit per day and six (6) units per covered person per benefit year.	• Self-referral – Provider referral is not required. • No prior authorization is needed • Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of practice chiropractic.	Yes

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EXHIBIT 10.L

HEALTHY INDIANA PLAN 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 January 1, 2017 through December 31, 2021.

Note on Rates and Rate Adjustment:

To the extent covered benefits or State-directed fee schedules are adjusted, capitation rates will be subject to revision in order to reflect the required program change. Future capitation rates will also be adjusted each year to reflect new base year data.

From time to time the State may adjust other fee schedules related to covered services for which reimbursement is not State-directed, as defined in 42 CFR 438.6(c)(iii), under this Contract. Where reimbursement is not State-directed, the Contractor may negotiate separate and distinct reimbursement with service providers, constrained only by other Contract provisions, such as access requirements. Should the State change these other fee schedules, there will be no related capitation rate adjustment.

Note on Risk and Acuity Adjustment:

Each Contractor's rates are 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.

FSSA reserves the right to change risk adjustment models and tools. Risk scores are calculated separately for each major rate grouping, using an aggregate approach, and are applied to age / gender specific rates. FSSA reserves the right to adjust rates retrospectively. Members enrolled for less than six (6) months were risk adjusted according to each Contractor's average risk adjustment factor.

Note on Retroactive Acuity Adjustment:

For the initial HIP CY 2020 rates, Contractor-specific acuity adjustment was applied to the rates instead of the typical budget neutral risk adjustment. Each Contractor's initial CY 2020 rates were adjusted based on this acuity adjustment. In the CY 2020 amendment, these rates were adjusted further to reflect an updated, retroactive Contractor-specific acuity adjustment, based on the morbidity of the Contractor's enrolled members in March 2020. This acuity adjustment process is described in further detail in the CY 2020 HIP rate certification report.

The Contractor's 2021 capitation rates shall be adjusted using 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.

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

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. FSSA reserves the right to change risk adjustment models and tools.

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 calendar year 2020 experience. 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 enrolled members. For the time period January 2021 through July 2021, the State intends to use all members enrolled as of April 2021 using experience from the 12 months prior (April 2020 through March 2021). For the time period August 2021 through December 2021, the State intends to use all members enrolled as of October 2021 using experience from the 12 months prior (October 2020 through September 2021). In aggregate, 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. The State reserves the right to base the acuity adjustment applied for CY 2021 on enrollment from months other than April 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).

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, 2017 – one point eight two percent (1.82%)
- Year 2, 2018 – two point zero five percent (2.05%)
- Year 3, 2019 – two point zero five percent (2.05%)
- Year 4, 2020 – two point zero five percent (2.05%)
- Year 5, 2021 – two point zero five percent (2.05%)
- Year 6, 2022 – four point five six percent (4.56%)

The 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.4.a of Contract Exhibit 4. Withhold payments will be calculated as set forth in Section B.4.a of Contract Exhibit 4.

Note on Section 9010 Health Insurer Fees:

Actuarial soundness requires all applicable fees and taxes be reflected in the rates. This includes the health insurer fee (HIF) implemented under Section 9010 of the Affordable Care Act. An adjustment has been applied to the CY 2020 rates, as amended. However, the HIF was repealed

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

effective calendar year 2021. As a result, no reimbursement for the HIF will be included in the calendar year 2021 capitation rates.

Note on Risk Corridor:

For calendar years 2020 and 2021 the State is implementing a two-sided risk corridor around the benefit cost portion of per member per month capitation rates. This risk corridor calculation shall be calculated separately for each Contractor, by program and year. The Contractor shall retain at most two percent (2%) of the overall gains or losses. The Contractor is at full risk for the first one point five percent (1.5%) of gains or losses. For gains and losses over one point five percent (1.5%) and up to two point five percent (2.5%) the State and Contractor shall share the risk evenly. Gains or losses above the first two point five percent (2.5%) revert to the State.

The targeted benefit cost shall be calculated by the State for each Contractor by program and year. The targeted benefit cost shall be calculated according to the method described in the actuarial certification for each applicable Contract year incorporated in this Contract by reference.

The actual benefit cost incurred by the Contractor shall include all regular medical expenditures in the encounter data. For sub-contracted services, only the amount paid to providers may be included; sub-contracted administrative costs are excluded. Expenditures will be evaluated net of selected costs, including third-party liability, pharmacy supplemental rebates, and net reinsurance recoveries. Benefit costs do not include non-encounterable data.

A reconciliation, to be calculated and finalized at the sole discretion of the State, will compare the actual per member per month benefit cost incurred by the Contractor to the targeted benefit cost, and result in a per member per month amount. The dollar value of the remittance is the product of the per member per month amount and the Contractor's calendar year member months.

The State shall perform an interim reconciliation of the calendar year 2020 risk corridor using claim experience with dates of service from January through June of calendar year 2020, allowing for runout through September 30, 2020. A full reconciliation of calendar year 2020 dates of service will occur using claim experience with runout through September 30, 2021.

The calendar year 2021 risk corridor reconciliation schedule will mirror the calendar year 2020 risk corridor reconciliation schedule. The calendar year 2021 risk corridor will use the same methodology for determining the target benefit cost but use the CY 2021 capitation rates as a basis. The calendar year 2021 risk corridor will have the same tiered structure and parameters as the calendar year 2020 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.

In this exhibit:

- The CY 2018 and CY 2020 rates include an adjustment for the HIF
- The CY 2017, CY 2019, and CY 2021 rates do not include an adjustment for the HIF. It is not anticipated that the rates will be adjusted for HIF, since the fee was not collected for these years.

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Note on Calendar Year 2017 Capitation Rates:

No further adjustments to the Calendar Year 2017 capitation rates are anticipated.

2017 Healthy Indiana Plan Capitation Rates
Effective January 1, 2017-March 31, 2017

All rates before adjustment for 1.82% withhold and after risk adjustment.

State Plan Benefits Package

Male – Basic	
19 – 24	$ 89.11
25 – 34	162.78
35 - 44	210.47
45 and Over	299.51

Female – Basic	
19 – 24	$ 90.77
25 - 34	179.67
35 - 44	276.96
45 and Over	357.52

Male – Plus	
19 - 24	$ 203.53
25 - 34	320.83
35 - 44	479.34
45 and Over	657.67

Female – Plus	
19 - 24	$ 161.12
25 - 34	329.53
35 - 44	538.92
45 and Over	685.86

Healthy Indiana Plan

Male – Basic	
19 – 24	$ 61.91
25 - 34	122.93
35 - 44	176.66
45 - 54	267.95
55 - 64	285.34

Female – Basic	
19 - 24	$ 60.94
25 - 34	93.82
35 - 44	155.72
45 - 54	271.82
55 - 64	240.11

Male – Plus	
19 - 24	$ 128.58
25 - 34	213.25
35 - 44	298.33
45 - 54	482.07
55 – 64	495.46

Female – Plus	
19 - 24	$ 138.84
25 - 34	209.39
35 - 44	351.47
45 - 54	491.88
55 - 64	503.02

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Medically Frail - Basic	$ 736.55
Medically Frail - Plus	$ 1,356.47
Pregnant Females - State Plan	$ 567.24
Pregnant Females - HIP	$ 493.33
Maternity Case Rate - State Plan	$ 7,241.76
Maternity Case Rate - HIP	$ 7,774.16
Hospital Presumptive Eligibility	$ 1,240.33

2017 Healthy Indiana Plan Capitation Rates
Effective April 1, 2017-June 30, 2017

All rates before adjustment for 1.82% withhold and after risk adjustment.

State Plan Benefits Package

Male – Basic	
19 – 24	$ 88.48
25 – 34	162.86
35 - 44	205.81
45 and Over	291.78

Female – Basic	
19 – 24	$ 85.52
25 - 34	172.66
35 - 44	267.68
45 and Over	350.92

Male – Plus	
19 - 24	$ 199.67
25 - 34	314.16
35 - 44	468.42
45 and Over	637.85

Female – Plus	
19 - 24	$ 150.70
25 - 34	313.63
35 - 44	519.45
45 and Over	661.58

Healthy Indiana Plan

Male – Basic	
19 – 24	$ 62.42
25 - 34	122.83
35 - 44	177.50
45 - 54	274.08
55 - 64	296.67

Female – Basic	
19 - 24	$ 58.44
25 - 34	90.56
35 - 44	152.41
45 - 54	266.63
55 - 64	241.30

Male – Plus	
19 - 24	$ 125.91
25 - 34	206.96
35 - 44	292.68
45 - 54	476.27
55 – 64	490.40

Female – Plus	
19 - 24	$ 132.53
25 - 34	197.82
35 - 44	335.78
45 - 54	472.14
55 - 64	489.78

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Medically Frail - Basic	$ 731.72
Medically Frail - Plus	$ 1,315.01
Pregnant Females - State Plan	$ 536.17
Pregnant Females - HIP	$ 470.03
Maternity Case Rate - State Plan	$ 8,133.06
Maternity Case Rate - HIP	$ 8,663.99
Hospital Presumptive Eligibility	$ 1,261.74

2017 Healthy Indiana Plan Capitation Rates
Effective July 1, 2017-December 31, 2017

All rates before adjustment for 1.82% withhold and after risk adjustment.

State Plan Benefits Package

Male – Basic	
19 – 24	$ 95.26
25 – 34	177.25
35 - 44	225.12
45 and Over	320.19

Female – Basic	
19 – 24	$ 95.46
25 - 34	190.12
35 - 44	293.83
45 and Over	383.62

Male – Plus	
19 - 24	$ 211.96
25 - 34	338.38
35 - 44	504.07
45 and Over	692.51

Female – Plus	
19 - 24	$ 165.97
25 - 34	341.35
35 - 44	561.10
45 and Over	718.61

Healthy Indiana Plan

Male – Basic	
19 – 24	$ 67.08
25 - 34	133.86
35 - 44	193.40
45 - 54	296.37
55 - 64	321.35

Female – Basic	
19 - 24	$ 65.19
25 - 34	100.94
35 - 44	168.06
45 - 54	293.65
55 - 64	263.96

Male – Plus	
19 - 24	$ 135.55
25 - 34	224.23
35 - 44	317.41
45 - 54	517.02
55 – 64	536.37

Female – Plus	
19 - 24	$ 145.15
25 - 34	216.93
35 - 44	368.28
45 - 54	516.77
55 - 64	535.05

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Medically Frail - Basic	$ 790.59
Medically Frail - Plus	$ 1,422.73
Pregnant Females - State Plan	$ 579.84
Pregnant Females - HIP	$ 505.29
Maternity Case Rate - State Plan	$ 8,578.71
Maternity Case Rate - HIP	$ 9,108.90
Hospital Presumptive Eligibility	$ 1,382.29

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EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Note on Calendar Year 2018 Capitation Rates (Planned Future Rate Adjustments):

No further adjustments to the Calendar Year 2018 capitation rates are anticipated.

2018 Healthy Indiana Plan Capitation Rates
Effective January 1, 2018-July 31, 2018

All rates before adjustment for 2.05% withhold and after risk adjustment.

State Plan Benefits Package

Male – Basic	
19 – 24	$ 144.47
25 – 34	168.42
35 - 44	236.31
45 and Over	314.36

Female – Basic	
19 – 24	$ 129.85
25 - 34	207.00
35 - 44	294.20
45 and Over	427.33

Male – Plus	
19 - 24	$ 277.42
25 - 34	348.61
35 - 44	554.21
45 and Over	709.14

Female – Plus	
19 - 24	$ 216.21
25 - 34	416.87
35 - 44	636.71
45 and Over	767.27

Healthy Indiana Plan

Male – Basic	
19 – 24	$ 100.11
25 - 34	165.83
35 - 44	232.87
45 - 54	343.44
55 - 64	403.34

Female – Basic	
19 - 24	$ 103.97
25 - 34	147.32
35 - 44	195.48
45 - 54	311.30
55 - 64	303.87

Male – Plus	
19 - 24	$ 199.03
25 - 34	297.08
35 - 44	379.63
45 - 54	567.02
55 – 64	588.69

Female – Plus	
19 - 24	$ 189.03
25 - 34	261.00
35 - 44	411.64
45 - 54	567.41
55 - 64	570.76

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Medically Frail - Basic	$ 855.51
Medically Frail - Plus	$ 1,501.20
Pregnant Females - Composite	$ 632.84
Maternity Case Rate - Composite	$ 7,734.76
Hospital Presumptive Eligibility	$ 1,484.29

2018 Healthy Indiana Plan Capitation Rates
Effective August 1, 2018-December 31, 2018

All rates before adjustment for 2.05% withhold and after risk adjustment.

State Plan Benefits Package

Male – Basic	
19 – 24	$ 153.34
25 – 34	178.94
35 - 44	250.74
45 and Over	333.42

Female – Basic	
19 – 24	$ 135.59
25 - 34	219.39
35 - 44	310.44
45 and Over	455.43

Male – Plus	
19 - 24	$ 285.87
25 - 34	365.36
35 - 44	581.87
45 and Over	743.94

Female – Plus	
19 - 24	$ 225.88
25 - 34	436.71
35 - 44	668.68
45 and Over	807.19

Healthy Indiana Plan

Male – Basic	
19 - 24	$ 105.60
25 - 34	177.68
35 - 44	251.33
45 - 54	373.69
55 - 64	436.75

Female – Basic	
19 - 24	$ 109.79
25 - 34	157.07
35 - 44	208.76
45 - 54	335.27
55 - 64	327.38

Male – Plus	
19 - 24	$ 207.07
25 - 34	314.30
35 - 44	402.91
45 - 54	605.01
55 – 64	632.03

Female – Plus	
19 - 24	$ 197.27
25 - 34	273.40
35 - 44	434.12
45 - 54	601.05
55 - 64	606.29

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Medically Frail - Basic	$ 911.52
Medically Frail - Plus	$ 1,581.44
Pregnant Females - Composite	$ 660.64
Maternity Case Rate - Composite	$ 8,550.13
Hospital Presumptive Eligibility	$ 1,601.13

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EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Note on Calendar Year 2019 Capitation Rates:

No further adjustments to the Calendar Year 2019 capitation rates are anticipated.

2019 Healthy Indiana Plan Capitation Rates
Effective January 1, 2019-July 31, 2019

All rates before adjustment for 2.05% withhold and after risk adjustment.

State Plan Benefits Package

Male – Basic	
19 – 24	$ 167.64
25 – 34	190.36
35 - 44	275.86
45 and Over	536.66

Female – Basic	
19 – 24	$ 151.17
25 - 34	240.85
35 - 44	352.48
45 and Over	486.32

Male – Plus	
19 - 24	$ 293.29
25 - 34	337.60
35 - 44	522.47
45 and Over	827.41

Female – Plus	
19 - 24	$ 234.16
25 - 34	421.67
35 - 44	666.18
45 and Over	839.15

Healthy Indiana Plan

Male – Basic	
19 - 24	$ 98.76
25 - 34	172.78
35 - 44	223.29
45 - 54	339.67
55 - 64	428.72

Female – Basic	
19 - 24	$ 105.83
25 - 34	146.44
35 - 44	199.82
45 - 54	311.07
55 - 64	363.78

Male – Plus	
19 - 24	$ 203.34
25 - 34	270.51
35 - 44	351.50
45 - 54	526.31
55 – 64	577.74

Female – Plus	
19 - 24	$ 178.30
25 - 34	246.35
35 - 44	350.41
45 - 54	519.54
55 - 64	538.35

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Medically Frail - Basic	$ 836.47
Medically Frail - Plus	$ 1,388.11
Pregnant Females - Composite	$ 594.91
Maternity Case Rate - Composite	$ 8,760.15
Hospital Presumptive Eligibility	$ 625.74

2019 Healthy Indiana Plan Capitation Rates
Effective August 1, 2019-December 31, 2019

All rates before adjustment for 2.05% withhold and after risk adjustment.

State Plan Benefits Package

Male – Basic	
19 – 24	$ 160.66
25 – 34	182.31
35 - 44	262.87
45 and Over	503.21

Female – Basic	
19 – 24	$ 145.91
25 - 34	231.70
35 - 44	338.05
45 and Over	461.67

Male – Plus	
19 - 24	$ 285.11
25 - 34	326.48
35 - 44	504.34
45 and Over	790.98

Female – Plus	
19 - 24	$ 227.36
25 - 34	409.70
35 - 44	645.99
45 and Over	808.26

Healthy Indiana Plan

Male – Basic	
19 - 24	$ 94.81
25 - 34	164.15
35 - 44	210.40
45 - 54	317.30
55 - 64	399.44

Female – Basic	
19 - 24	$ 102.63
25 - 34	140.29
35 - 44	191.31
45 - 54	295.58
55 - 64	342.69

Male – Plus	
19 - 24	$ 196.69
25 - 34	259.08
35 - 44	335.36
45 - 54	499.23
55 – 64	545.40

Female – Plus	
19 - 24	$ 173.82
25 - 34	238.70
35 - 44	337.84
45 - 54	498.46
55 - 64	513.11

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Medically Frail - Basic	$ 798.65
Medically Frail - Plus	$ 1,335.75
Pregnant Females - Composite	$ 579.45
Maternity Case Rate - Composite	$ 7,932.60
Hospital Presumptive Eligibility	$ 594.44

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EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Note on Calendar Year 2020 Capitation Rates:

No further adjustments to the Calendar Year 2020 capitation rates are anticipated.

2020 Healthy Indiana Plan Capitation Rates
Effective January 1, 2020-July 31, 2020

All rates before adjustment for 2.05% withhold and after risk adjustment.

State Plan Benefits Package

Male – Basic	
19 – 24	$ 131.37
25 – 34	202.21
35 - 44	351.87
45 and Over	460.61

Female – Basic	
19 – 24	$ 173.92
25 - 34	265.87
35 - 44	391.71
45 and Over	596.81

Male – Plus	
19 - 24	$ 376.33
25 - 34	495.82
35 - 44	649.21
45 and Over	932.69

Female – Plus	
19 - 24	$ 257.89
25 - 34	427.90
35 - 44	697.99
45 and Over	913.37

Healthy Indiana Plan

Male – Basic	
19 - 24	$ 99.04
25 - 34	145.30
35 - 44	202.17
45 - 54	303.95
55 - 64	384.99

Female – Basic	
19 - 24	$ 94.44
25 - 34	133.05
35 - 44	188.56
45 - 54	296.91
55 - 64	314.82

Male – Plus	
19 - 24	$ 200.96
25 - 34	262.22
35 - 44	337.14
45 - 54	481.49
55 – 64	562.81

Female – Plus	
19 - 24	$ 170.04
25 - 34	224.01
35 - 44	317.59
45 - 54	483.93
55 - 64	496.30

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Medically Frail - Basic	$ 820.34
Medically Frail - Plus	$ 1,349.91
Pregnant Females - Composite	$ 602.47
Maternity Case Rate - Composite	$ 8,553.15

2020 Healthy Indiana Plan Capitation Rates
Effective August 1, 2020-December 31, 2020

All rates before adjustment for 2.05% withhold and after risk adjustment.

State Plan Benefits Package

Male – Basic	
19 – 24	$ 139.08
25 – 34	203.70
35 - 44	340.11
45 and Over	469.29

Female – Basic	
19 – 24	$ 175.95
25 - 34	262.33
35 - 44	386.37
45 and Over	563.90

Male – Plus	
19 - 24	$ 379.82
25 - 34	483.86
35 - 44	637.75
45 and Over	909.96

Female – Plus	
19 - 24	$ 248.28
25 - 34	413.31
35 - 44	678.28
45 and Over	886.65

Healthy Indiana Plan

Male – Basic	
19 - 24	$ 97.92
25 - 34	143.01
35 - 44	205.21
45 - 54	306.15
55 - 64	378.83

Female – Basic	
19 - 24	$ 94.60
25 - 34	134.43
35 - 44	191.77
45 - 54	300.56
55 - 64	320.22

Male – Plus	
19 - 24	$ 186.55
25 - 34	251.59
35 - 44	334.78
45 - 54	473.55
55 – 64	557.85

Female – Plus	
19 - 24	$ 166.13
25 - 34	218.50
35 - 44	310.69
45 - 54	474.19
55 - 64	484.02

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Medically Frail - Basic	$ 800.89
Medically Frail - Plus	$ 1,269.94
Pregnant Females - Composite	$ 615.47
Maternity Case Rate - Composite	$ 9,742.95

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EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

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 changes made to the PFAC or other State-directed fee schedules during CY 2021
- Adjustment to apply retrospective acuity adjustment based on actual 2021 risk scores

2021 Healthy Indiana Plan Capitation Rates
Effective January 1, 2021 - July 31, 2021

All rates before adjustment for 2.05% withhold and after risk adjustment.

Non-Expansion Healthy Indiana Plan State Plan Members

Male – Basic	
19 – 24	$ 115.82
25 – 34	242.68
35 - 44	343.82
45 and Over	496.61

Female – Basic	
19 – 24	$ 180.99
25 - 34	295.14
35 - 44	471.02
45 and Over	652.59

Male – Plus	
19 - 24	$ 273.44
25 - 34	398.68
35 - 44	603.60
45 and Over	860.78

Female – Plus	
19 - 24	$ 217.63
25 - 34	372.62
35 - 44	623.53
45 and Over	850.11

Expansion Healthy Indiana Plan Non-State Plan and State Plan Members

Male – Basic	
19 - 24	$ 158.28
25 - 34	343.10
35 - 44	483.43
45 - 54	754.54
55 - 64	887.00

Female – Basic	
19 - 24	$ 209.21
25 - 34	320.09
35 - 44	524.30
45 - 54	802.42
55 - 64	886.60

Male – Plus	
19 - 24	$ 329.52
25 - 34	533.80
35 - 44	663.52
45 - 54	1,024.17
55 – 64	1,102.69

Female – Plus	
19 - 24	$ 280.07
25 - 34	415.25
35 - 44	596.31
45 - 54	927.38
55 - 64	961.51

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Pregnant Females - Composite	$ 393.04
Maternity Case Rate - Composite	$ 9,792.78

2021 Healthy Indiana Plan Capitation Rates
Effective August 1, 2021 - December 31, 2021

All rates before adjustment for 2.05% withhold and after risk adjustment.

Non-Expansion Healthy Indiana Plan State Plan Members

Male – Basic	
19 – 24	$ 110.81
25 – 34	224.69
35 - 44	315.70
45 and Over	449.91

Female – Basic	
19 – 24	$ 165.13
25 - 34	274.35
35 - 44	433.39
45 and Over	592.16

Male – Plus	
19 - 24	$ 265.77
25 - 34	399.25
35 - 44	594.34
45 and Over	833.55

Female – Plus	
19 - 24	$ 215.84
25 - 34	375.55
35 - 44	621.38
45 and Over	835.55

Expansion Healthy Indiana Plan Non-State Plan and State Plan Members

Male – Basic	
19 - 24	$ 144.23
25 - 34	317.82
35 - 44	440.54
45 - 54	679.67
55 - 64	792.74

Female – Basic	
19 - 24	$ 189.39
25 - 34	295.04
35 - 44	476.92
45 - 54	721.86
55 - 64	792.10

Male – Plus	
19 - 24	$ 326.48
25 - 34	536.39
35 - 44	662.16
45 - 54	1,001.86
55 – 64	1,067.67

Female – Plus	
19 - 24	$ 281.50
25 - 34	420.01
35 - 44	598.28
45 - 54	916.98
55 - 64	940.62

EXHIBIT 10.L

HEALTHY INDIANA PLAN CAPITATION RATES

Other HIP Groups

Pregnant Females - Composite	$ 515.22
Maternity Case Rate - Composite	$ 9,425.69

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