

405-26-84248 - Healthy Indiana Plan Independent Evaluator Procurement
Scope of Work
Attachment K

1. PROGRAM OVERVIEW

Indiana currently has the authority to continue to operate the Healthy Indiana Plan (HIP) under section 1115(a) authority through December 31, 2030. Under this ten-year renewal, HIP will continue to provide health care coverage for adults via managed care and a plan design that incorporates a high-deductible consumer-driven health plan, and an account similar to a health savings account (HSA), called a Personal Wellness and Responsibility (POWER) account. HIP members are required to make monthly premium contributions to their POWER accounts. Unlike traditional premiums, however, HIP members own their contributions and are entitled to their portion of unused contributions if they leave the program.

As required under the Special Terms and Conditions (STCs - Attachment L, Bidders' Library) with the Centers for Medicare and Medicaid Services (CMS), the Indiana Family and Social Services Administration (FSSA) is seeking to contract with an independent evaluator to conduct a comprehensive evaluation of the HIP program. Proposals to serve as the independent evaluator for HIP should demonstrate that the contractor has the expertise to conduct an evaluative study of a major health care program that builds on other published research where appropriate, meets the prevailing standards of scientific and academic rigor, and provides statistically valid and reliable results. Note that the evaluation of the Substance Use Disorder (SUD) and Serious Mental Illness programs, which are also included in the STCs, are separate from the services being sought with this RFP.

1.1 Background

From 2008 to 2014, HIP provided coverage to a limited number of low-income individuals (approximately 50,000 per year) based on state funding availability. HIP achieved significant success, with ninety-five percent (95%) of members reporting that they were satisfied with the program, and ninety-eight percent (98%) indicating that they would re-enroll if they left the program and became eligible again.

In 2014, former Governor Mike Pence, opted to use HIP as the vehicle for Medicaid expansion in Indiana. Known as "HIP 2.0", a three-year demonstration (February 1, 2015 – January 31, 2018) continued upon the success of the first six years of the program. In particular, an independent evaluation found descriptive evidence that members who contributed to their POWER Accounts (versus members who did not contribute) were twice as likely to obtain primary care (31% to 16%); had better prescription medication adherence (84% to 67%); and relied less on the emergency room for treatment (775 to 1,034 visits per 1,000-member years). Moreover, ninety percent (90%) of members indicated that they would be willing to pay more to stay in HIP, and only five percent (5%) of members were disenrolled for failure to contribute to their POWER account. By the end of the demonstration, over 400,000 members were enrolled, in HIP, with two-thirds making regular contributions to their POWER account. In 2018, CMS approved a three-year waiver renewal of HIP 2.0, through December 31, 2020, and in 2020 CMS approved the current 10-year waiver renewal (January 1, 2021-December 31, 2030).

As of June 2025, HIP enrollment has reached over 600,000 members and is the second largest Medicaid Program.

1.2 Program Description

Under HIP, members who make required monthly contributions to their POWER Account maintain access to an enhanced benefit plan, known as “HIP Plus”, which includes enhanced health care benefits such as coverage for dental, vision, and chiropractic services. HIP Plus is intended to encourage personal responsibility, improve healthy behaviors, and develop cost conscious consumer behaviors among all beneficiaries.

Beneficiaries with income at or below 100 percent of the federal poverty level (FPL) who do not make monthly POWER Account contributions will be defaulted to a more limited benefit plan, known as “HIP Basic”. HIP Basic is a fully qualified essential health benefit package, but the plan offers more limited benefits (for example not covering vision or dental services) and applies copayments to all healthcare services in place of the required contributions in HIP Plus.

Members with family income above the 100 percent poverty level will be terminated from HIP for non-payment of required monthly contributions, consistent with commercial market policies. These members do not have access to the HIP Basic plan. Notwithstanding the foregoing, individuals determined medically frail, regardless of income, are exempt from non-payment penalties and do not lose benefits due to non-payment of POWER account contributions. Certain members, including the medically frail and low-income parents and caretakers are exempt from benefit plan changes, and receive full Medicaid benefits, regardless of payment status, however, these individuals continue to have the opportunity to make payments in the form of required contributions, or default into HIP State Basic copayments.

Unlike traditional premiums or copayments, HIP members own their POWER account contributions and are entitled to their portion of unused contributions when they leave the program. Due to the direct financial investment in the POWER account, HIP members are incentivized to manage their accounts judiciously and to take advantage of free preventive care services offered by the plan outside of the member’s POWER account. For this reason, POWER accounts remain a critical feature of HIP and are provided to every HIP member, regardless of their benefit plan. To further incentivize healthy behaviors, members who obtain preventive services are eligible to reduce their future POWER account contributions amounts.

Through the combination of incentives and disincentives, HIP intends to actively engage HIP members in their healthcare and achieve improved outcomes as compared to traditional Medicaid.

1.3 Demonstration Goals

The goals of HIP reflect the successes and lessons learned since HIP implementation in 2008. From 2015 to 2018 the goals of HIP were mainly aligned with the original program goals and included the following:

1. Reduce the number of uninsured low-income Indiana residents and increase access to healthcare services
2. Promote value-based decision making and personal health responsibility
3. Promote disease prevention and health promotion to achieve better health
4. Promote private market coverage and family coverage options to reduce network and provider fragmentation within families
5. Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance
6. Assure State fiscal responsibility and efficient management of the program

Starting with the renewal February 1, 2018 the formal stated goals of the demonstration included in the STCs were:

1. Monthly POWER account payments will result in improved health care access, utilization, and health outcomes among HIP members;
2. Implementing a community engagement requirement will lead to sustainable employment and improved health care access, utilization, and health outcomes among HIP members; and
3. Charging beneficiaries an increased monthly contribution for tobacco use will discourage tobacco use and increase the utilization of tobacco cessation benefits.

Starting with the current renewal, beginning January 1, 2021, the formal stated goals of the demonstration included in the STCs are:

1. Improve health care access, appropriate utilization, and health outcomes among HIP members;
2. Discourage tobacco use among HIP members through premium surcharge and the utilization of tobacco cessation benefits;
3. Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure;
4. Ensure HIP program policies align with commercial policies, encourage members understanding, and promote positive member experience and minimize gaps in coverage; and
5. Assess the costs to implement and operate HIP and other non-cost outcomes for the demonstration.

2. EVALUATION OVERVIEW

The State is required to evaluate the HIP 1115 waiver demonstration to determine its overall impact on Indiana Medicaid and its members. The evaluation must include components that are needed to satisfy the Centers for Medicare and Medicaid Services (CMS) requirements for evaluation of an 1115 waiver, as outlined in the CMS Special

Terms and Conditions (STCs) for the demonstration (see Attachment L, Bidders' Library) and must assist the state in determining the overall context of HIP in terms of member health outcomes, utilization, and member access. The evaluation will determine if Indiana is making sufficient progress on the goals that the State is seeking to achieve, under section 1.3 "Demonstration Goals".

2.1 Key Tasks and Vendor Experience

The tasks below may be required as part of the Evaluation Design approved by CMS. Respondents shall demonstrate proficiency and experience in each of the following and/or provide narrative of consideration of comparable experience in the Technical Proposal, Attachment F:

1. Evaluating statewide healthcare delivery programs;
2. Evaluating programs authorized through the Centers for Medicare and Medicaid Services (CMS) or other federal health agency;
3. Evaluation of health programs of at least 100,000 participants
4. Developing evaluation plans;
5. Identifying evaluation metrics;
6. Developing hypotheses and accompanying research questions to test hypotheses;
7. Developing driver diagrams;
8. Developing survey tools/instruments;
9. Conducting statewide member surveys;
10. Conducting telephone surveys;
11. Conducting internet-based surveys;
12. Conducting focus groups;
13. Conducting Key Informant Interviews;
14. Conducting qualitative data analysis;
15. Presenting the results and findings of qualitative data analysis into formal reports;
16. Conducting quantitative data analysis using at minimum, each of the following:
 - a. Regression analysis;
 - b. Longitudinal data analysis;
 - c. Difference in Differences Analysis; and
 - d. Statistical significance testing.
17. Presenting the results and findings of quantitative data analysis into formal reports;
18. Storing collected data in a secure location;
19. Collecting data from state Medicaid Management Information Systems (MMISs);
20. Cleaning and interpreting data from state MMISs;
21. Responding to comments and edits to formal report drafts;
22. Updating formal reports, based on comments and edits;
23. Developing policy recommendations based on evaluation outcomes; and

24. Identifying local, regional, and national policy implications of evaluation results.
25. Review previous evaluator's reports for awareness of content and bridging understanding to subsequent evaluations
26. Developing reports that comply with Section 508 of the Rehabilitation Act

2.2 Communications and Meetings

The Contractor shall:

1. Facilitate an in-person kick off meeting with the Indiana Family and Social Services Administration (FSSA). Contractor shall include all project staff at the kickoff meeting and provide a detailed agenda and meeting summary;
2. Assign a qualified Project Manager who will serve as a direct point of contact and engage in day-to-day communication with the State;
3. Meet weekly with FSSA via Teams or Zoom to discuss process, progress, barriers, and any other related issues proposed by FSSA or the Contractor related to evaluation activities. With FSSA approval meetings may be canceled or held less frequently;
4. Provide a detailed agenda in advance of each meeting;
5. Provide a summary of the previous meeting in advance of each meeting;
6. Provide progress reports on any evaluation activity as FSSA requests;
7. If requested by FSSA, following the submission of any deliverable to FSSA, provide an oral presentation and accompanying PowerPoint file to FSSA or other stakeholders regarding its review and any recommendations. Relevant members of the Contractor team, including the Program Director and Project Manager, shall be present. Contractor shall submit a draft PowerPoint presentation at least three (3) business days prior to the meeting and submit a final electronic copy to FSSA within two (2) business days of the meeting;
8. Request the permission and approval of FSSA before any data or reports related to the evaluation are released. FSSA shall pre-approve all requests for use of its data. Research, including that needed for the evaluation components of this plan and any research using FSSA data above and beyond that contracted by the State, shall be approved by FSSA prior to commencement. The Contractor shall agree to submit to FSSA a copy of all findings, articles, and any other similar documents that are developed using the Indiana FSSA data, within thirty (30) days of completion. The Contractor agrees that no data concerning the HIP waiver will be disclosed by the Contractor or published in a format that identifies FSSA without the written permission of the State; and

9. Notify the State prior to presentation of any report or their findings related to HIP or the evaluation of HIP, including in related national publications (including, for example, journal articles). Prior to release of these publications or presentations, the State will be provided a copy including any associated press materials. The State will be given fourteen (14) days to review and comment on materials before they are released.

3. EVALUATION DELIVERABLES

The Contractor shall propose and come to an agreement with FSSA on a set of timelines for the completion of the required deliverables. Estimated timelines are provided in Section 4 based on the STCs and a demonstration start date of January 1, 2021. If agreement cannot be reached, due dates shall be set by FSSA in the best interest of the State. The Contractor shall utilize any and all dates as indicated in the HIP 1115 demonstration STCs (Attachment L, Bidders' Library). The Contractor shall adhere to all evaluation requirements indicated in the HIP 1115 demonstration STCs.

3.0 Project Management Activities

This task encompasses project management and monitoring activities and will include the following activities:

A. Project kick-off meeting – The contractor will organize and facilitate this meeting within two weeks of approval to begin work, provide a meeting agenda two business days in advance of the meeting, and distribute meeting notes and work plans no later than five business days after the meeting. Meeting topics are anticipated to include:

- (i) Review and discuss State goals, contractor's work plan, and related timelines
- (ii) Identify key resource materials
- (iii) Other topics as needed

B. State Meetings – The contractor will conduct regular meetings with FSSA staff dedicated to the HIP waiver, including distribution of meeting agendas at least one business day in advance, and providing meeting notes within five business days of each meeting. The contractor will work with FSSA staff to tailor the frequency of status meetings to each phase of the work. For example, weekly meetings would occur during the more intensive phases of quantitative analysis, while monthly meetings would be more likely during less intensive periods of work.

C. Monthly progress reports – Beginning on the 15th of the month following the contract start date, and continuing monthly throughout the contract, the contractor will submit a project progress report to FSSA.

3.1 Ad-hoc Evaluation Design

As required by CMS, the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

3.1.1 Draft Evaluation Design

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation.

No later than 180 days after approval of the demonstration, the State must submit a draft Evaluation Design to CMS. Since this demonstration did not begin recently and FSSA has an approved 2021-2030 evaluation design, the State intends to build on this design at the request of CMS unless a new design is requested by CMS. Coordinating with FSSA on the finalization of the evaluation design, engaging with federal partners during the evaluation design plan review phase, updating the evaluation design per CMS comments, and maintaining the evaluation design as necessary will be key responsibilities of the Contractor.

In development of an updated evaluation design, FSSA intends to leverage as appropriate the prior two CMS approved HIP evaluation designs (Attachment L, Bidders' Library). FSSA's goal for the Evaluation Design for the ongoing waiver period is to enhance and modify the prior approved evaluation designs to provide a rigorous study of health outcomes, member access, and utilization of services that provide overall context on the impacts and outcomes of HIP. Under this evaluation FSSA intends for the Contractor to leverage program data from the beginning of HIP 2.0 in February 2015 through the end of the reporting period (subject to change).

In discussion with CMS, a reasonable due date will be pursued if a revised or new evaluation design is requested by CMS. Since there isn't an established due date and the deliverable is subject to CMS' request, this task will be considered its own ad-hoc deliverable. **For the purpose of completing Attachment D, the cost proposal, complete Task 3.1 under the assumption of a revised evaluation design, not new.** Alternatively, if CMS requests a new design, ad-hoc funds may be executed.

The format for the Evaluation Design is detailed in the HIP STCs (Attachment L, Bidders' Library) but will be required to include the following sections:

1. General Background Information
2. Evaluation Questions and Hypotheses
3. Methodology
4. Methodological Limitations
5. Attachments

3.1.2 Final Evaluation Design

Following the submission of the revised evaluation design to CMS, it is expected that the Contractor will support FSSA in discussions with CMS relating to the Evaluation Design. Following discussions of the design, CMS may provide formal written comments to the state on the Evaluation Design. The Contractor must, in coordination with the state, update the Draft Evaluation Design, provide an updated draft for state review, and provide a Final Evaluation Design for submission to CMS. **For the purpose of completing Attachment D, the cost proposal, include the cost of making the final evaluation design section 508 compliant.**

3.2 Interim Evaluation Report

The Contractor must submit an Interim Evaluation Report for the completed years of the demonstration. The draft interim evaluation report must be made available to FSSA with sufficient time for review, comments, and updates, prior to the submission to CMS.

For the Interim Evaluation Report, FSSA intends to provide an evaluation of the impact of HIP on health outcomes, members access, and utilization from demonstration years 1-8 (calendar years 2021-2028). FSSA's goal for the Interim Evaluation Report is to provide robust quantitative and qualitative analysis of the impacts and outcomes of HIP as related to member health, access to care, utilization of services and the preliminary identification of the factors that positively and negatively impact these target areas, as well as the determined strength of the identified associations. The interim report should also seek to conduct analysis of process measures and preliminary pre-post analysis on the policies that changed with the implementation of the renewal waiver. In addition, FSSA intends that the interim evaluation report will provide narrative and descriptive statistics on other active HIP policies, including tobacco cessation. The interim report must align with the approved CMS Evaluation design discussed in 3.1 and is required to be posted for public comment with the State's application for waiver renewal. Based on the current approval period, the 2021-2028 Interim Evaluation will be due when the application for renewal is submitted.

To summarize, the Interim Evaluation Report will encompass the following:

1. Discuss evaluation progress and present findings to date as per the approved evaluation design.
2. Include data and outcomes from the first five demonstration years (i.e., HIP 2.0; February 1, 2015 through December 31 2020 (subject to change)) and demonstration years 2021-2028.

The Interim Evaluation Report must include at minimum the following sections, described in the HIP STCs (Attachment L, Bidders' Library):

1. Executive Summary;
2. General Background Information;
3. Evaluation Questions and Hypotheses;

4. Methodology;
5. Methodological Limitations;
6. Results;
7. Conclusions;
8. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
9. Lessons Learned and Recommendations; and
10. Attachment(s).

As of the development of this scope of work, there is a pause on a subset of HIP policies, resulting in a lack of data available for meaningful analysis of research questions in the approved evaluation design. These policy pauses were initially put in place during the COVID-19 PHE, further limiting the quality of meaningful data available for analysis. Impacted research questions include those related to Fast Track, tobacco premium surcharges, switches from HIP Plus to HIP Basic, POWER account payments, and rollover. Additionally, there are research questions that cannot be answered for the evaluation period because they were designed to evaluate policies for which Indiana no longer has authority to implement through the HIP 2.0 1115 waiver and therefore no longer includes in the current program design. These policies include non-eligibility or “lockout” periods and Gateway to Work (work requirements). Lastly, the contractor will not be evaluating goal six, HIP Workforce Bridge Account evaluation questions, or goal five, costs to implement and operate HIP and other non-cost outcomes of the demonstration. Goal five will be completed by the State’s Actuary, and the contractor will work with the State’s Actuary to append the goal five report to the interim evaluation report. **For the purpose of the cost schedule, do not include goal five and six due to permanently suspended policies. Costs for research questions 1 through 4, including research questions related to temporarily paused policies should be included in the event the pause is lifted during the evaluation period and after the development of this scope of work.** If the policies are reinstated and evaluated by the contractor, they will be reimbursed for 100% of the deliverable. If the policies remain suspended throughout the reporting period and are therefore not evaluated by the contractor, the State will reduce the deliverable’s reimbursement by 10%-20%. Prior to any reduction, the percentage will be discussed with the Contractor. The contractor will be eligible for the percentage if alternative research questions or alternative reporting metrics result from an updated evaluation design or are suggested by CMS to make the evaluation more comprehensive. **For the purpose of completing Attachment D, the cost proposal, and public comment include the cost of ensuring the draft interim evaluation is in compliance with the requirements under Section 508 of the Rehabilitation Act.**

3.2.1 Final Interim Evaluation Report

Following the submission of the interim report to CMS, it is expected that the Contractor will support FSSA in discussions with CMS relating to the report. Following their review, CMS may provide formal written comments to the state on the report. The Contractor must, in coordination with the state, incorporate or address the feedback via an updated draft for state review, and therefore a final

interim report for submission to CMS. **For the purpose of completing attachment D, the cost proposal, include the cost of making the final interim report, once CMS approved, section 508 compliant.**

3.3 Summative Evaluation Report

The Contractor must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the Demonstration. The draft Summative Evaluation Report must be made available to FSSA with sufficient time for review, comments, and updates, prior to the submission to CMS.

For the Summative Evaluation Report, FSSA intends to provide a holistic assessment evaluation of the impact of the current 1115 HIP demonstration on health access, utilization and outcomes among Indiana Medicaid beneficiaries. FSSA's goal for the Summative Evaluation Report is to provide comprehensive quantitative and qualitative analysis of the impacts and outcomes of HIP as related to member health, access to care, and utilization of services, as well as summary identification of the factors that positively and negatively impact these target areas, including the determined strength of the identified associations. The summative report must also analyze process measures and provide summative pre-post analysis on the policies that changed with the implementation of the renewal waiver. The summative report must align the approved CMS Evaluation Design discussed in 3.1.

The Summative Evaluation Report must adhere to the following format:

1. Executive Summary;
2. General Background Information;
3. Evaluation Questions and Hypotheses;
4. Methodology;
5. Methodological Limitations;
6. Results;
7. Conclusions;
8. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
9. Lessons Learned and Recommendations; and
10. Attachment(s).

As of the development of this scope of work, there is a pause on a subset of HIP policies, resulting in a lack of data available for meaningful analysis of research questions in the approved evaluation design. These policy pauses were initially put in place during the COVID-19 PHE, further limiting the quality of meaningful data available for analysis. Impacted research questions include those related to Fast Track, tobacco premium surcharges, switches from HIP Plus to HIP Basic, POWER account payments, and rollover. Additionally, there are research questions that cannot be answered for the evaluation period because they were designed to evaluate policies for which Indiana no

longer has authority to implement through the HIP 2.0 1115 waiver and therefore no longer includes in the current program design. These policies include non-eligibility or “lockout” periods and Gateway to Work (work requirements). Lastly, the contractor will not be evaluating goal six, HIP Workforce Bridge Account evaluation questions, or goal five, costs to implement and operate HIP and other non-cost outcomes of the demonstration. Goal five will be completed by the State’s Actuary, and the contractor will work with the State’s Actuary to append the goal five report to the interim evaluation report. **For the purpose of the cost schedule, do not include goal five and six due to permanently suspended policies. Costs for research questions 1 through 4, including research questions related to temporarily paused policies should be included in the event the pause is lifted during the evaluation period and after the development of this scope of work.** If the policies are reinstated and evaluated by the contractor, they will be reimbursed for 100% of the deliverable. If the policies remain suspended throughout the reporting period and are therefore not evaluated by the contractor, the State will reduce the deliverable’s reimbursement by 10%-20%. Prior to any reduction, the percentage will be discussed with the Contractor. The contractor will be eligible for the percentage if alternative research questions or alternative reporting metrics result from an updated evaluation design or are suggested by CMS to make the evaluation more comprehensive. **For the purpose of completing Attachment D, the cost proposal, and public comment include the cost of ensuring the draft summative evaluation is in compliance with the requirements under Section 508 of the Rehabilitation Act**

3.3.1 Final Summative Evaluation Report

Following the submission of the summative report to CMS, it is expected that the Contractor will support FSSA in discussions with CMS relating to the report. Following their review, CMS may provide formal written comments to the state on the report. The Contractor must, in coordination with the state, incorporate or address the feedback via an updated draft for state review, and therefore a final interim report for submission to CMS. **For the purpose of completing attachment D, the cost proposal, include the cost of making the final summative report, once CMS approved, section 508 compliant.**

3.4 Ad Hoc Analyses and Reports

Given the evolving nature of demonstration projects, FSSA might require additional analysis. The Contractor may conduct ad hoc analyses and accompanying reports, per state fiscal year, as requested by the State. If pursued, a contract amendment may be required.

4. Deliverables Timeline and Schedule

The following tables detail when each deliverable will be due by the Contractor during each state fiscal year. The timeline provided is based upon the 1115 waiver approval received by FSSA on October 26, 2020, and a contract for this Scope of Work (SOW) beginning on a date to be determined.

Deadlines are subject to change based upon CMS requirements and the Contract start date. Therefore, the State may update the timeline during contract preparation with the awarded Contractor.

Table 4.1 Evaluation Design Deliverables

Deliverable	Contractor Deadline for Submission to State (“Contractor Deadline”)	State Deadline for Submission to CMS
4.1.1 Updated Draft Evaluation Design	TBD	TBD
4.1.2 Revised Evaluation Design	30 days after receiving CMS written feedback	60 days after receiving CMS written feedback

Table 4.2 Interim Evaluation Deliverables

Deliverable	Contractor Deadline for Submission to State (“Contractor Deadline”)	State Deadline for Submission to CMS
4.2.1 DY 1-8 Draft Interim Evaluation*	September 1, 2029	December 31, 2029
4.2.2 DY 1-8 Revised Interim Evaluation	30 days after receiving CMS written feedback	60 days after receiving CMS written feedback

*Deliverable will be due earlier from the contractor since the HIP waiver will be due for renewal in 2029

Table 4.3 Summative Evaluation Deliverables

Deliverable	Contractor Deadline for Submission to State (“Contractor Deadline”)	State Deadline for Submission to CMS
4.3.1 Draft Summative Evaluation	May 1, 2032	June 30, 2032
4.3.2 Revised Summative Evaluation	30 days after receiving CMS written feedback	60 days after receiving CMS written feedback

Table 4.4 Other Deliverables

Deliverable	Contractor Deadline for Submission to State (“Contractor Deadline”)	State Deadline for Submission to CMS
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4.4.1 Ad Hoc Analysis 1 (as requested)	As agreed	N/A
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5. Staffing

The Contractor shall staff the project team appropriately to assure that it can meet the responsibilities defined in the Contract and the STCs in an efficient, effective, and timely manner. This shall require project team staff with the necessary expertise and in adequate number to perform or administer the activities.

The Contractor should submit a staffing plan with position qualifications to FSSA to ensure completion of all required deliverables. FSSA may conduct an annual review of the Contractor's staffing plan to determine whether any changes in the personnel or number of staff are required to complete the deliverables. FSSA shall have final approval of any replacement personnel proposed following Contract activation or any time during the Contract.

The Contractor will staff the following Key Staff positions which include, but are not limited to:

- Program Director
- Project Manager
- Data Manager
- Statistician

The Contractor shall at minimum propose doctoral level (e.g., PhD) staff for the Projector Director and Statistician positions. In the absence of doctoral level staff, the Contractor shall provide assurance to FSSA that these Key Staff positions meet the quality and performance of doctoral level staff.

6. Accessing State Databases

The Contractor may be required to work with the State's technical team to receive access to various State databases or receive data extracts. The Contractor must be willing to sign a Data Use Agreement with the State and be able to transfer the data in a way which meets the Health Insurance Portability and Accountability Act (HIPAA) requirements for the transfer of sensitive data.

7. Billing and Invoicing

The State intends to compensate the Contractor on a deliverable basis. Each deliverable will be priced by type in the cost proposal (see Attachment D, Cost Proposal).

Payments for the following deliverables will be made after the deliverable is submitted to FSSA on-time, approved by FSSA, finalized, and sent to CMS (if applicable):

- Ad Hoc Reports (Table 4.4)

Further, payments for each of the following deliverables will be made in two increments as set forth in the Deliverable Payment Schedule Table below:

- Evaluation Design (Table 4.1)
- Interim Evaluation Report (Table 4.2)
- Summative Evaluation Report (Table 4.3)

Table 7. Deliverable Payment Schedule

Milestone Achieved	% of Total Deliverable Due
Initial draft deliverable approved by the State and submitted to CMS	75% of the deliverable's Contract amount will be paid
Final deliverable approved by CMS after incorporating CMS feedback	25% of the deliverable's Contract amount will be paid.

8. Timeliness Performance

As untimely completion of a deliverable has less value, the following Table lists the reduced payments due to the Contractor for the Contractor's untimely completion of a deliverable if the Contractor fails to complete and submit an acceptable deliverable by the respective deliverable's Contractor Deadline set forth in Section 4. There will be an exception if the failure to complete the milestone can be attributed to the State's material delay or material failure to comply with its obligations.

Table 8. Deliverable Timeline Timeliness Performance

Untimely Delivery Measurement	Payment Due to Contractor
Delivery after Contractor Deadline	(Deliverable Cost) – (A percentage, not to exceed 5%, of the Deliverable Cost, reasonably representing the decreased value provided to the State due to the late delivery)
Delivery for each week (5 business days) after the Contractor Deadline	(Deliverable Cost) – (A percentage, not to exceed 5%, of the Deliverable Cost, reasonably representing the decreased value provided to the State due to the late delivery multiplied by the number of weeks delayed)

9. Corrective Action and Payment Withholds

It is the State's primary goal to ensure that the Contractor is accountable for delivering services as defined and agreed to in the Contract. This includes, but is not limited to, performing all items described in the Scope of Work, completing all deliverables in a timely manner described in the Scope of Work, and generally performing to the

satisfaction of the State. Failure to perform in a satisfactory manner may result in corrective actions and withholds described below. It is the intent of FSSA to remedy any non-performance through specific remedies and a payment withholding protocol. If the Contractor fails to meet requirements set forth in the Contract, 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. The State will provide written notice of non-compliance to the Contractor within thirty (30) calendar days of the State's discovery of such non-compliance.

9.1 Corrective Actions

If the State determines that the Contractor is not performing to the satisfaction of the State, has not completed any deliverable in a satisfactory or timely manner, or upon written request by the State for any reason, the Contractor shall submit, within ten (10) business days of the occurrence or State request, a Corrective Action Plan (CAP). The nature of the corrective action(s) will depend upon the nature, severity, and duration of the deficiency and repeated nature. Severity shall be determined by the State, in its sole discretion.

At a minimum, the CAP shall address the causes of the deficiency, the impacts and the measures being taken and/or recommended to remedy the deficiency, and whether the solution is permanent or temporary. It must also include a schedule showing when the deficiency will be remedied, and for when the permanent solution will be implemented, if appropriate.

9.2 Payment Withholds

Beginning the month in which a CAP is required per the Corrective Actions paragraph above, the State may withhold 10% of the following deliverable's invoice and all subsequent billing until the CAP is implemented. When the CAP is completed and the proposed remedy is implemented, all monies withheld shall be returned to the Contractor within 30 days. Should the CAP not be submitted as required or should the remedy not be implemented within the timeframe specified by the CAP, the monies will continue to be withheld until the ability to perform in a satisfactory manner is demonstrated to the sole discretion of the State. In addition, the State reserves the right to pursue appropriate legal recourse for damages it sustains because of this failure to perform.

The Contractor and the State shall schedule monthly meetings to discuss the Contractor's performance. The Contractor is required to show satisfactory progress towards milestones and otherwise provide information that can be used to show that performance is satisfactory. Scheduling of review meetings shall be agreed upon mutually between Contractor and the State.