Subject: 2017 updates to provider attachments

Dear Provider/Facility/Hospital:

After careful review, Anthem Blue Cross and Blue Shield (Anthem) has determined that our 2017 Hoosier Healthwise/Healthy Indiana Plan contract with the Indiana Office of Medicaid Policy and Planning requires updates to your attachments regarding those programs. Please see the enclosed amendment for further detail.

This amendment is a result of newly implemented regulatory changes and other program modifications in our contract with the state, which take effect January 1, 2017.

Thus, the effective date of this amendment is also January 1, 2017.

For administrative ease, Anthem is enclosing updated attachments for both the Hoosier Healthwise and Healthy Indiana Plan programs. However, we acknowledge that not all providers participate in both networks. If you only participate in one or the other, please disregard the attachment that is not applicable to you.

Additionally, Anthem is enclosing one set of updated attachments per tax ID number. Therefore, if you have multiple Anthem contracts for various services, but all contracts are tied to a single tax ID, you will only receive one communication applicable to all of your Anthem contracts. Please ensure you keep a copy of the attachments with each of your Anthem contracts.

All other provisions of the agreement shall remain in full force and effect. In the event of a conflict between the provision of this amendment and the provisions of the agreement, the provisions set forth in this amendment shall control.

We request you carefully read the enclosed, revised Participation Attachments to your Anthem Blue Cross and Blue Shield Agreement. The amendment contains full details of all new and updated information.

If you have questions regarding this amendment, please call 1-866-408-6132 (Hoosier Healthwise) or 1-800-345-4344 (Healthy Indiana Plan) and your inquiry will be routed to the appropriate Anthem representative.

Sincerely,

www.anthem.com/inmedicaiddoc
David T. Lee, M.D.
Regional Vice President, Provider Solutions
Anthem Blue Cross and Blue Shield

Enclosure: 2017 Indiana Medicaid/HIP Participation Attachments to the Anthem Blue Cross and Blue Shield Agreement
This is a unilateral Amendment ("Amendment") pursuant to the paragraph of the applicable Anthem Blue Cross and Blue Shield Agreement ("Agreement") between Anthem Insurance Companies, Inc. doing business as Anthem Blue Cross and Blue Shield (hereinafter "Anthem") and Facility/HOSPITAL/Provider/PROFESSIONAL PROVIDER/ANCILLARY PROVIDER (hereinafter all referred to as "Provider") that addresses the permissibility of unilateral amendments and/or the paragraph of the applicable Participation Attachment addressing regulatory updates and is incorporated into the Agreement as follows:

1. The Healthy Indiana Plan Participation Attachment to the applicable ANTHEM BLUE CROSS AND BLUE SHIELD Agreement is hereby amended to conform with the contractual requirements between Anthem and the State of Indiana Healthy Indiana Plan (HIP) program, effective January 1, 2017.

2. The Indiana Medicaid Participation Attachment to the applicable ANTHEM BLUE CROSS AND BLUE SHIELD Agreement is hereby amended to conform with the contractual requirements between Anthem and the State of Indiana Hoosier Healthwise program, effective January 1, 2017.

3. For administrative ease, both Hoosier Healthwise and Healthy Indiana Plan Participation Attachments are incorporated in this Amendment. However this Amendment is in no way intended to modify the current Network participation of a Provider. Only the Participation Attachments applicable to Provider’s current Agreement shall be amended in accordance herewith.

4. For administrative ease, the applicable Participation Attachments shall apply to all Agreements between Anthem and Provider under the Tax ID identified below.

5. For purposes of this Amendment and the attachments hereto, references to Anthem shall also encompass ANTHEM as applicable to the Agreement[s] subject to this Amendment.

6. All other provisions of the Agreement(s) shall remain in full force and effect. In the event of a conflict between the provision of this Amendment and the provisions of the Agreement(s), the provisions set forth in this Amendment shall control.

PROVIDER LEGAL NAME ________________________________________________

Tax Identification Number (TIN): __________________

Anthem Insurance Companies, Inc.
dba Anthem Blue Cross and Blue Shield

THE EFFECTIVE DATE OF THIS AMENDMENT IS: January 1, 2017

By: ___________________________________________ ____________________________________
Signature, Authorized Representative of Anthem Date

Printed: David T. Lee, MD Regional VP Provider Solutions
Name Title
Address: P.O. Box 7171 Indianapolis IN 46207-7171
Street City State Zip
HEALTHY INDIANA PLAN
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER/PROVIDER/ANCILLARY PROVIDER AGREEMENT

This Healthy Indiana Plan Participation Attachment to the Anthem Blue Cross and Blue Shield PROFESSIONAL PROVIDER/Provider/ANCILLARY PROVIDER/Ancillary Provider Agreement (the "Agreement") as applicable is entered into by and between Anthem and PROFESSIONAL PROVIDER/Provider/ANCILLARY PROVIDER/ Ancillary Provider and is incorporated into the Agreement. For purposes of this Attachment all references to Provider shall encompass PROFESSIONAL PROVIDER/ANCILLARY PROVIDER/ Ancillary Provider and all references to Anthem shall also encompass ANTHEM as well.

1. This Healthy Indiana Plan Participation Attachment (the "Attachment") is limited to the terms and conditions governing the provision of and payment for Health Services provided to Healthy Indiana Plan enrollees who are also enrolled in the Healthy Indiana Plan managed care program administered by Anthem (hereinafter referred to as "Healthy Indiana Plan Covered Individuals or HIP Covered Individuals"). Provider agrees to participate as a Network Provider in Anthem's managed care Healthy Indiana Plan Network (hereinafter "Healthy Indiana Plan Network") and to provide Health Services to Healthy Indiana Plan Covered Individuals.

2. For purposes of this Attachment, "Healthy Indiana Plan" means the health care coverage plan provided under Indiana House Bill 1678 that extends health care coverage to certain low-income, uninsured Indiana consumers without access to employer sponsored health insurance. For purposes of this Attachment, "Covered Services" means those Medically Necessary Health Services for which a Healthy Indiana Plan Covered Individual is eligible.

3. All of Provider's duties and obligations to Covered Individuals set forth in the Agreement shall also apply to Healthy Indiana Plan Covered Individuals. In addition, Provider agrees to the following with respect to Healthy Indiana Plan Covered Individuals:

   a. Maintain a current Indiana Health Coverage Programs ("IHCP") provider agreement and comply with all IHCP regulations;

   b. Maintain medical care standards and practice guidelines as set forth and detailed in the IHCP Provider Reference Modules and/or Medicaid Policy Manual but not limited to utilizing the Indiana Health Coverage Program Prior Authorization Form available on the Indiana Medicaid website for submission of prior authorization requests to Anthem;

   c. Respond to cultural, racial and linguistic needs of Healthy Indiana Plan Covered Individuals;

   d. Comply with the terms applicable to Provider set forth in 1) the Request for Services issued by the State of Indiana in connection with the Healthy Indiana Plan, 2) the managed care organization ("MCO") contract, including incorporated documents, between Anthem and the State of Indiana, which applicable terms are incorporated herein by reference and 3) the Provider Operations Manual. Anthem agrees to provide Provider with a description of the applicable terms in the MCO contract;

   e. Be duly licensed in accordance with the applicable state licensing board. Provider further agrees to remain in good standing with said board;

   f. Obtain and maintain all required permits, licenses and approvals and comply with all applicable health, safety and environmental statutes, rules, regulations or ordinances necessary for the performance of Health Services;

   g. Comply with all state and federal laws, rules, regulations and ordinances, as amended, applicable to Healthy Indiana Plan Covered Individuals;

   h. Cooperate and comply with Anthem's Provider Appeals Process as set forth in the Provider Operations Manual for purposes of Claims dispute resolution;

   i. Submit all Claims for Health Services rendered to Healthy Indiana Plan Covered Individuals that do not involve a third party payor within ninety (90) calendar days from the date of service. Anthem
shall waive the timely filing requirement in the case of Claims for Healthy Indiana Plan Covered Individuals with retroactive coverage, such as presumptively eligible pregnant women and newborns;

j. Cooperate with any program designed to monitor Healthy Indiana Plan compliance by providers who participate in Anthem's Healthy Indiana Plan Network and comply with any corrective actions related thereto if Provider is out of compliance with the Office of Medicaid Policy and Planning ("OMPP") or Anthem's standards;

k. Submit all encounter Claims for Health Services rendered to Healthy Indiana Plan Covered Individuals in accordance with Anthem's specifications for the submission of such encounter data. This provision shall survive termination of this Attachment for services rendered to Healthy Indiana Plan Covered Individuals while Provider is a Network Provider;

l. Provide a copy of a Healthy Indiana Plan Covered Individual's medical record at no charge upon reasonable request by the Healthy Indiana Plan Covered Individual;

m. Facilitate the transfer of the Healthy Indiana Plan Covered Individual’s medical record to another provider at said Healthy Indiana Plan Covered Individual's request, at no charge;

n. Cooperate with and permit evaluations, through on-site inspection or other means, during normal business hours, of the quality, appropriateness, and timeliness of Health Service rendered to Healthy Indiana Plan Covered Individuals. Such evaluations may be conducted by Anthem, OMPP, the Office of Children's Health Insurance Program, the Department of Health and Human Services, or other duly authorized state agency;

o. Cooperate with and permit inspections upon reasonable notice and at reasonable times of any records, medical or financial, pertinent to Provider's delivery of Health Services to Healthy Indiana Plan Covered Individuals. Such inspections may be conducted by Anthem, OMPP, other duly authorized state agency, or their representative;

p. Maintain an adequate record keeping system for recording services, charges, date and other commonly accepted information elements for Health Services rendered to Healthy Indiana Plan Covered Individuals, including, without limitation, the following:

i. Prescriptions for medications;

ii. Inpatient discharge summaries;

iii. Patient histories (including immunizations) and physicals;

iv. A list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs; and

v. A record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and x-ray tests and findings.

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

Confidentiality of, and access to, medical records must be provided in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and all other state and federal requirements.

q. Participate in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Anthem for Healthy Indiana Plan Covered Individuals;

r. Observe and protect the rights of Healthy Indiana Plan Covered Individuals;
s. Provide Health Services to Healthy Indiana Plan Covered Individuals for a minimum of thirty (30) calendar days or until the Healthy Indiana Plan Covered Individual finds another source of primary care, if Provider is designated by Anthem as a primary care Provider and Provider no longer participates in the Healthy Indiana Plan Network but continues to be an IHCP Provider;

t. Comply with the requirements of 42 CFR 489, Subpart I, related to maintaining and distributing written policies and procedures respecting advance directives;

u. Prepare and submit reports as requested by OMPP or other duly authorized state office (hereinafter "Office") by the completion date established by the Office. Such requests will be limited to situations in which the desired data is considered essential and cannot be reasonably obtained through standard Anthem reports;

v. In the event of Anthem's insolvency, continue to provide Health Services to Healthy Indiana Plan Covered Individuals until the end of the month in which insolvency has occurred and to provide inpatient Health Services until the date of discharge for any Healthy Indiana Plan Covered Individual institutionalized when insolvency occurs;

w. Maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under this Attachment and make such materials available at the respective offices at all reasonable times during the term of this Attachment, and for three (3) years from the date of final payment under this Attachment, for inspection by the state or its authorized designees. Copies shall be furnished at no cost to the state if requested.

x. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments (CLIA) certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment;

y. Provider shall ask and encourage Healthy Indiana Plan Covered Individuals to sign a consent that permits release of substance abuse treatment information to Anthem and other providers.

If Provider is a behavioral health Provider or providing behavioral health services, the following provisions shall also apply:

a. Provider shall ensure that Healthy Indiana Plan Covered Individuals receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge and that such follow-up and/or continuing treatment is within seven (7) calendar days from the date of the Healthy Indiana Plan Covered Individual's discharge. If the Healthy Indiana Plan Covered Individuals misses the follow-up and/or continuing treatment that was scheduled within seven (7) calendar days from the date of the Healthy Indiana Plan Covered Individual's discharge, Provider shall contact the Healthy Indiana Plan Covered Individuals within three (3) business days of the notification of the missed appointment.

aa. Provider shall notify Anthem and the Healthy Indiana Plan Covered Individual's Primary Care Provider within five (5) calendar days of a Healthy Indiana Plan Covered Individual who is at risk for hospitalization or who has had a hospitalization, and submit the following information to Anthem and the Healthy Indiana Plan Covered Individual's Primary Care Provider:

   i. A written summary of the initial assessment session
   ii. Primary and secondary diagnoses
   iii. Medication prescribed
   iv. Psychotherapy prescribed
   v. Any other relevant information

bb. Provider shall notify Anthem and the Healthy Indiana Plan Covered Individual's Primary Care Provider of a Healthy Indiana Plan Covered Individual who is not at risk for hospitalization, and submit the following information to Anthem and the Healthy Indiana Plan Covered Individual's Primary Care Provider within five (5) calendar days of the initial session:
i. A written summary of the initial visit and a summary of the findings, including:
   ii. Provider's contact information
   iii. Visit Date
   iv. Presenting problem and diagnosis
   v. Medication prescribed
   vi. Psychotherapy prescribed
   vii. Any other relevant information

cc. Provider shall notify Anthem and the Healthy Indiana Plan Covered Individual's PCP of any significant changes in the Healthy Indiana Plan Covered Individual's status and/or a change in the level of care.

4. Termination of Healthy Indiana Plan Network Attachment.
   a. This Attachment shall automatically terminate upon the occurrence of any one of the following:
   i. Termination of Provider's license;
   ii. Termination of Provider's IHCP Provider agreement;
   iii. Failure to comply with section 3.f above;
   iv. Termination/expiration of Anthem's managed care organization contract with the State of Indiana in accordance with IC 12-15-30-5;
   v. Failure to meet OMPP's or Anthem's credentialing standards for the Healthy Indiana Plan Network;
   vi. Failure to meet OMPP's access and availability standards;
   vii. Provider's exclusion from participation in federal health care programs under Section 1128 or Section 1128A of the Social Security Act; or
   viii. Failure to meet other quality improvement program standards.
   b. Either party hereto may terminate this Attachment without cause upon ninety (90) calendar days prior written notice to the other party without affecting the Agreement, amendments, addenda, or other attachments, or Provider's participation in other Network(s).
   c. If either party fails to comply with or perform any term or condition of this Attachment, the other party shall notify the defaulting party of its default in writing, and the defaulting party shall have thirty (30) days to cure the default. If the default is not cured within said thirty (30) day period, this Attachment is automatically terminated, unless otherwise specified by the non-defaulting party.

5. This Attachment shall be automatically amended to conform to applicable changes to state or federal laws, rules, regulations or ordinances related to Healthy Indiana Plan Covered Individuals or the Healthy Indiana Plan without the necessity of executing written amendments.

   a. The HIP Anthem Rate is based on one hundred percent (100%) of the State of Indiana Medicare Fee Schedule or one hundred thirty percent (130%) of the Indiana Medicaid Fee Schedule if the service does not have a Medicare reimbursement rate (collectively referred to herein as the “Fee Schedule”) on file with Anthem, as of the effective date of the Healthy Indiana Plan Participation Attachment or Provider’s billed charge, whichever is less, and is paid in accordance with Exhibit A. Provider acknowledges that reimbursement for some Covered Services may first be made from the Healthy Indiana Plan Covered Individual’s POWER Account, with any remaining balance payable by Anthem. Provider agrees that under no circumstances shall he/she/it balance bill the Healthy Indiana Plan Covered Individual. For purposes of this Attachment, “POWER Account” means an individual health care account funded by, at minimum, the State of Indiana and the Healthy Indiana Plan Covered...
Individual and used by that Covered Individual to purchase Covered Services before their deductible is met.

b. Upon notice of any changes to the Fee Schedule, Anthem reserves the right to review, accept and implement such change before it shall be deemed effective. Anthem will notify Provider in writing of the new rates and effective date according to the Notice section of the Agreement.

c. Provider agrees that Anthem's payment constitutes payment in full for any Covered Services rendered to Healthy Indiana Plan Covered Individuals. Provider agrees to use best commercial efforts to collect any required copayments for Covered Services rendered to Healthy Indiana Plan Covered Individuals. Provider agrees it shall not seek payment from the Healthy Indiana Plan Covered Individual, his/her representative or the State of Indiana for any Health Services rendered pursuant to this Attachment. This section should not be interpreted as interfering with Provider's ability to hold Healthy Indiana Plan Covered Individuals liable for the emergency services copayment or payment of Covered Services with POWER Account funds before the Healthy Indiana Plan Covered Individual's deductible has been met. Healthy Indiana Plan Covered Individuals may not be held liable for any of the following:

i. Any payments for Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the Anthem Rate;

ii. Covered Services provided to the Healthy Indiana Plan Covered Individual for which OMPP does not pay Anthem;

iii. Covered Services provided to the Healthy Indiana Plan Covered Individual for which OMPP or Anthem does not pay the Provider that furnishes the services under a contractual, referral or other arrangement;

iv. Anthem's debts in the event of Anthem's insolvency; and

v. Provider may not balance bill Healthy Indiana Plan Covered Individuals, i.e., charge the Healthy Indiana Plan Covered Individuals for Covered Services above the amount paid to Provider by Anthem.

7 Nothing herein shall be construed to prohibit Provider from contracting with other Healthy Indiana Plan managed care organizations.

8. Provider acknowledges that Healthy Indiana Plan Covered Individuals shall have access to Provider's rates. Such rates, as well as quality information regarding Provider, may be made available on Anthem's member web site.

9. Nothing herein will be construed to prohibit or restrict Provider from advising a Healthy Indiana Plan Covered Individual about her/his health status, medical care, or treatment, or the risks, benefits and consequences of treatment or non-treatment, regardless of whether benefits for such care are available for the Healthy Indiana Plan Covered Individual, if Provider is acting within the lawful scope of practice. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

10. Provider certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Attachment by any federal agency or by any department, agency or political subdivision of the state. For purposes of this Attachment, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Provider's operations. Provider shall immediately notify Anthem if it or any of its principals becomes debarred or suspended, and Anthem shall, at the state's request, take all steps required by the state to terminate its contractual relationship with Provider for work to be performed under this Attachment.

11 Provider agrees to comply with the following:
a. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the regulation of the Department of Health and Human Services (45 CFR Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which Provider receives Federal assistance.

b. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which Provider receives Federal assistance.

c. The Age Discrimination Act of 1975 (Pub. L 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which Provider receives Federal assistance.

d. The Americans with Disabilities Act of 1990 (Pub. L. 101-336), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Justice (28 CFR 35.101 et seq.), to the end that in accordance with the Act and Regulation, no person in the United States with a disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Provider receives Federal financial assistance.

e. Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686), and all requirements imposed by or pursuant to regulation, to the end that, in accordance with the Amendments, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Provider receives Federal financial assistance.

f. I.C. 22-9-1-10 and the Civil Rights Act of 1964, as amended, and any other applicable state or federal law, regulations and executive orders prohibiting discrimination, in that Provider shall not discriminate against any employee or applicant for employment in the performance of this Attachment. Provider shall not discriminate with respect to the hire, tenure, terms, conditions or privileges of employment or any matter directly or indirectly related to employment, because of race, color, religion, sex, disability, national origin, ancestry or status as a veteran. Breach of this provision shall be considered default; and

g. All requirements applicable to Provider under the Health Insurance Portability and Accountability Act of 1996.

12. Order of Precedence. All other provisions of the Agreement shall remain in full force and effect. In the event of a) a conflict between the provisions of this Attachment and the Agreement, or b) any inconsistency or ambiguity in this Attachment, such conflict, inconsistency or ambiguity shall be resolved by giving precedence in the following order: i) state or federal law, rule, regulation or ordinance; ii) this Attachment; and iii) the Agreement.

13. Notice. Provider shall provide thirty (30) days prior notice of any change in information or status that would affect Healthy Indiana Plan Network participation or Claims payment status (e.g. change of address, physician status change, etc) to the following address:

Anthem Blue Cross and Blue Shield
Attn: Network Services
PO Box 7171
Indianapolis, IN 46207-7171

14. IHCP Providers are prohibited from charging a Healthy Indiana Plan Covered Individual, or the family of the Healthy Indiana Plan Covered Individual, for any amount not paid as billed for an IHCP Covered Service.
Provider acceptance of payment from Anthem as payment in full is a condition of participation in the IHCP. An IHCP Provider can bill a Covered Individual only when the following conditions have been met:

a. The service rendered must be determined to be non-covered by Anthem; or

b. The Healthy Indiana Plan Covered Individual has exceeded the program limitations for a particular service; and

c. The Healthy Indiana Plan Covered Individual must understand, before receiving the service, that the service is not covered by Anthem, and that the Healthy Indiana Plan Covered Individual is responsible for the charges associated with the service.

d. The Provider must maintain documentation that the Healthy Indiana Plan Covered Individual voluntarily chose to receive the service, knowing that Anthem did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the Healthy Indiana Plan Covered Individual signs the consent before receiving the service. See the IHCP Provider Reference Modules and/or Medicaid Policy Manual for more information.

e. In cases where prior authorization is denied, a Provider can bill a Healthy Indiana Plan Covered Individual for services if;

i. Provider establishes that authorization has been requested and denied prior to rendering the service:

ii. Provider has an opportunity to request review of the authorization decision by Anthem;

iii. If authorization is denied upon review, Provider must inform the Healthy Indiana Plan Covered Individual that the service requires authorization, and that authorization has been denied;

iv. The Healthy Indiana Plan Covered Individual must be informed of the right to contact Anthem to file an appeal if the Healthy Indiana Plan Covered Individual disagrees with the decision to deny authorization;

v. Provider must inform the Healthy Indiana Plan Covered Individual of his/her responsibility for payment if the Healthy Indiana Plan Covered Individual chooses to or insists on receiving the services without authorization;

vi. If a waiver is used to establish Healthy Indiana Plan Covered Individual responsibility for payment, use of such a waiver must meet the following requirements:

a. The waiver is signed only after the Healthy Indiana Plan Covered Individual receives the appropriate notification;

b. The waiver does not contain any language or condition to the effect that if authorization is denied, the Covered Individual is responsible for payment.

c. 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.

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

15. Provider must adhere to the following:

a. Primary Care Providers ("PCPs") who are not advance nurse practitioners must accept a panel of Healthy Indiana Plan Covered Individuals of at least one hundred (100) individuals. The foregoing does not require PCP to maintain a panel size as indicated, but merely prohibits PCP from closing his/her practice to new Healthy Indiana Plan Covered Individuals unless the panel size is reached. PCP is also not prohibited from accepting more Healthy Indiana Plan Covered Individuals than the indicated panel size. For group practices, the panel size indicated is for each PCP within the group but the total panel is calculated in the aggregate for the group."
b. PCPs who are advance practice nurse practitioners may not accept a panel size that exceeds five hundred (500) Healthy Indiana Plan Covered Individuals aggregated across all Managed Care Entities. Advance Practice Nurse Practitioner PCPs are responsible for monitoring their total panel size and reporting to Anthem when their panel reaches ninety-five percent (95%) of the maximum.

c. PCPs must provide or arrange for coverage of services twenty four (24) hours a day, seven (7) days a week;

d. PCPs must coordinate Healthy Indiana Plan Covered Individual's physical and behavioral health care;

e. PCPs must have a mechanism in place to offer Healthy Indiana Plan Covered Individuals direct contact with their PCP, or the PCP's qualified clinical staff person, through a toll-free telephone number twenty four (24) hours a day, seven (7) days a week;

f. Each PCP must be available to see Covered Individuals 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;

PCPs must provide "live voice" coverage after normal business hours. After hour coverage for the PCP may include an answering service or a shared-call system with other medical Providers.

*Except for Advance Practice Nurse Practitioners acting as PCPs group panel size is established on a per PCP basis but calculated in the aggregate for the group. Each PCP in the group is not required to have equal panel size. Thus a panel assignment of one hundred (100) Healthy Indiana Plan Covered Individuals for a group with three (3) PCPs means that the group as a whole must have three hundred (300) Healthy Indiana Plan Individuals before it may close its practice to new Healthy Indiana Plan Covered Individuals. The panel of three hundred (300) Healthy Indiana Plan Covered Individuals may be distributed among the three (3) PCPs in any configuration. All of the following configurations satisfy the requirement for a per PCP panel of one hundred (100) Healthy Indiana Plan Covered Individuals for a group of three (3) PCPs.

Ex. A.    PCP 1: 100  Ex. B.  PCP 1: 150  Ex. C.  PCP 1: 300
          PCP 2: 200  PCP 2: 150  PCP 2: 0
          PCP 3: 300  PCP 3: 0  PCP 3: 0
<table>
<thead>
<tr>
<th>Coded Service Identifier(s)</th>
<th>Anthem Rate</th>
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| Advance Practice Nurse Practitioner – Primary Medical Provider | 85% of the HIP Anthem Rate  
100% of the HIP Anthem Rate for the following Covered Services billed with the applicable codes:  
Radiology (70010 – 79999)  
Pathology and Lab (80048 – 89399)  
Immunizations (90281-90799)  
| Advance Practice Nurse Practitioner – non Primary Medical Provider - when billing with NPI assigned to Advance Practice Nurse Practitioner. | 85% of the HIP Anthem Rate - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified. |
| Advance Practice Nurse Practitioner – non Primary Medical Provider - employed by Provider and billing with the NPI assigned to a physician with modifier SA | 100% of the HIP Anthem Rate - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified. |
| All other provider types not specifically identified otherwise | 100% of the HIP Anthem Rate |
1. This Medicaid Participation Attachment (the "Attachment") is limited to the terms and conditions governing the provision of and payment for Health Services provided to Medicaid enrollees who are also enrolled in Anthem's managed care Medicaid program (hereinafter referred to as "Medicaid Covered Individuals"). Provider agrees to participate as a Network Provider in Anthem's managed care Medicaid network (hereinafter "Medicaid Network") and to provide Health Services to Medicaid Covered Individuals.

2. For purposes of this Attachment, "Medicaid" means medical assistance provided under a state plan approved under Title XIX of the Social Security Act. For purposes of this Attachment, "Covered Services" means those Medically Necessary Health Services for which a Medicaid Covered Individual is eligible.

3. All of Provider's duties and obligations to Covered Individuals set forth in the Agreement shall also apply to Medicaid Covered Individuals. In addition, Provider agrees to the following with respect to Medicaid Covered Individuals:
   a. Maintain a current Indiana Health Coverage Programs ("IHCP") provider agreement and comply with all IHCP regulations;
   b. Maintain medical care standards and practice guidelines as set forth and detailed in the IHCP Provider Reference Modules and/or Medicaid Policy Manual but not limited to utilizing the Indiana Health Coverage Program Prior Authorization Form available on the Indiana Medicaid website for submission of prior authorization requests to Anthem:
   c. Respond to cultural, racial and linguistic needs of Medicaid Covered Individuals;
   d. Be duly licensed in accordance with the applicable state licensing board of the State of Indiana. Provider further agrees to remain in good standing with said board;
   e. Obtain and maintain all required permits, licenses and approvals and comply with all applicable health, safety and environmental statutes, rules, regulations or ordinances necessary for the performance of Health Services;
   f. Comply with the terms applicable to providers set forth in 1) the Request for Services issued by the State of Indiana in connection with the Medicaid program, 2) the managed care organization ("MCO") contract, including incorporated documents, between Anthem and the State of Indiana, which applicable terms are incorporated herein by reference and 3) the Provider Operations Manual. Anthem agrees to provide Provider with a description of the applicable terms in the MCO contract;
   g. Comply with all state and federal laws, rules, regulations and ordinances, as amended, applicable to Medicaid Covered Individuals;
   h. Cooperate and comply with Anthem's Provider Appeals Process as set forth in the Provider Operations Manual for purposes of Claims dispute resolution;
   i. Submit all Claims for Health Services rendered to Medicaid Covered Individuals that do not involve a third party payor within ninety (90) calendar days from the date of service. Anthem shall waive the timely filing requirement in the case of Claims for Medicaid Covered Individuals with retroactive coverage, such as presumptively eligible pregnant women and newborns;
   j. Cooperate with any program designed to monitor Medicaid program compliance by providers who
participate in Anthem’s Medicaid Network and comply with any corrective actions related thereto if Provider is out of compliance with the Office of Medicaid Policy and Planning ("OMPP") or Anthem’s standards;

k. Submit all encounter Claims for Health Services rendered to Medicaid Covered Individuals in accordance with Anthem’s specifications for the submission of such encounter data; This provision shall survive termination of this Attachment for services rendered to Medicaid Covered Individuals while Provider is a Network Provider;

l. Provide a copy of a Medicaid Covered Individual’s medical record at no charge upon reasonable request by the Medicaid Covered Individual;

m. Facilitate the transfer of the Medicaid Covered Individual’s medical record to another provider at said Medicaid Covered Individual’s request, at no charge;

n. Cooperate with and permit evaluations, through on-site inspection or other means, during normal business hours, of the quality, appropriateness, and timeliness of Health Service rendered to Medicaid Covered Individuals. Such evaluations may be conducted by Anthem, OMPP, the Office of Children’s Health Insurance Program, the Department of Health and Human Services, or other duly authorized state agency;

o. Cooperate with and permit inspections upon reasonable notice and at reasonable times of any records, medical or financial, pertinent to Provider’s delivery of Health Services to Medicaid Covered Individuals. Such inspections may be conducted by Anthem, The Office of Medicaid Policy and Planning, the Office of Children’s Health Insurance Program, or other duly authorized state agency;

p. Maintain an adequate record keeping system for recording services, charges, date and other commonly accepted information elements for Health Services rendered to Medicaid Covered Individuals, including, without limitation, the following:

i. Prescriptions for medications;

ii. Inpatient discharge summaries;

iii. Patient histories (including immunizations) and physicals;

iv. A list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs; and

v. A record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and x-ray tests and findings.

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

Confidentiality of, and access to, medical records must be provided in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and all other state and federal requirements.

q. Participate in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Anthem for Medicaid Covered Individuals;

r. Comply with the requirements of 42 CFR 489, Subpart I, related to maintaining and distributing written policies and procedures respecting advance directives;

s. Observe and protect the rights of Medicaid Covered Individuals;

t. Provide Health Services to Medicaid Covered Individuals for a minimum of thirty (30) calendar days
or until the Medicaid Covered Individual finds another source of primary care, if Provider is designated by Anthem as a primary care provider and Provider no longer participates in the Medicaid Network but continues to be an IHCP provider;

u. Prepare and submit reports as requested by the Office of Medicaid Policy and Planning or the Office of Children's Health Insurance Program (hereinafter "Offices") by the completion date established by either of the Offices. Such requests will be limited to situations in which the desired data is considered essential and cannot be reasonably obtained through standard Anthem reports;

v. In the event of Anthem's insolvency, continue to provide Health Services to Medicaid Covered Individuals until the end of the month in which insolvency has occurred and to provide inpatient Health Services until the date of discharge for any Medicaid Covered Individual institutionalized when insolvency occurs.

w. Maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under this Attachment and make such materials available at the respective offices at all reasonable times during the term of this Attachment, and for three (3) years from the date of final payment under this Attachment, for inspection by the state or its authorized designees. Copies shall be furnished at no cost to the state if requested.

x. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments (CLIA) certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment; and

y. Provider shall ask and encourage Medicaid Covered Individuals to sign a consent that permits release of substance abuse treatment information to Anthem and other providers.

*If Provider is a behavioral health provider or providing behavioral health services, the following provisions shall also apply:*

a. Provider shall ensure that Medicaid Covered Individuals receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge and that such follow-up and/or continuing treatment is within seven (7) calendar days from the date of the Medicaid Covered Individual's discharge. If the Medicaid Covered Individuals misses the follow-up and/or continuing treatment that was scheduled within seven (7) calendar days from the date of the Medicaid Covered Individual's discharge, Provider shall contact the Medicaid Member within three (3) business days of the notification of the missed appointment.

aa. Provider shall notify Anthem and the Medicaid Covered Individual's Primary Care Provider within five (5) calendar days of a Medicaid Covered Individual who is at risk for hospitalization or who has had a hospitalization, and submit the following information to Anthem and the Medicaid Covered Individual's Primary Care Provider:

i. A written summary of the initial assessment session
ii. Primary and secondary diagnoses
iii. Medication prescribed
iv. Psychotherapy prescribed
v. Any other relevant information

bb. Provider shall notify Anthem and the Medicaid Covered Individual's Primary Care Provider of a Medicaid Covered Individual who is not at risk for hospitalization, and submit the following information to Anthem and the Medicaid Covered Individual's Primary Care Provider within five (5) calendar days of the initial session:

i. A written summary of the initial visit and a summary of the findings, including:
ii. Provider's contact information
iii. Visit Date
iv. Presenting problem and diagnosis
v. Medication prescribed
vi. Psychotherapy prescribed
vii. Any other relevant information
cc. Provider shall notify Anthem and the Medicaid Covered Individual's PCP of any significant changes in the Medicaid Covered Individual's status and/or a change in the level of care.

4. Termination of Medicaid Network Attachment.
   a. This Attachment shall automatically terminate upon the occurrence of any one of the following:
      i. Termination of Provider's license;
      ii. Termination of Provider's IHCP provider agreement;
      iii. Failure to comply with section 3. e) above;
      iv. Termination/expiration of Anthem's managed care organization contract with the State of Indiana in accordance with IC 12-15-30-5;
      v. Failure to meet OMPP's or Anthem's credentialing standards for the Medicaid Network;
      vi. Failure to meet OMPP's access and availability standards;
      vii. Provider's exclusion from participation in federal health care programs under Section 1128 or Section 1128A of the Social Security Act; or
      viii. Failure to meet other quality improvement program standards.
   b. Either party hereto may terminate this Attachment without cause upon ninety (90) calendar days prior written notice to the other party without affecting the Agreement, amendments, addenda, or other attachments, or Provider's participation in other Network(s).
   c. If either party fails to comply with or perform any term or condition of this Attachment, the other party shall notify the defaulting party of its default in writing, and the defaulting party shall have thirty (30) days to cure the default. If the default is not cured within said thirty (30) day period, this Attachment is automatically terminated, unless otherwise specified by the non-defaulting party.

5. This Attachment shall be automatically amended to conform to applicable changes to state or federal laws, rules, regulations or ordinances related to Medicaid Covered Individuals or the Indiana Medicaid program without the necessity of executing written amendments.

   a. For primary care providers ("PCP"), the Anthem Rate for the Medicaid Network shall continue in accordance with Provider’s compensation in effect on December 31, 2016 for the specific provider type ("Fee Schedule") on file with Anthem, as of the effective date of the Medicaid Participation Attachment except for those CPT codes and provider types specifically identified on the attached Medicaid Network Compensation Exhibit A, incorporated herein by reference or Provider's billed charge, whichever is less. Payment for Covered Services submitted with the CPT codes or by the provider types set forth on said Exhibit A will be reimbursed based on the Anthem Rate corresponding to the CPT code or provider type as identified. For purposes of this Attachment, "primary care provider (PCP)" means the following types of health care providers: internal medicine physicians, general practice physicians, family practice physicians, pediatricians, obstetric/gynecology physicians, endocrinologists (if primarily engaged in internal medicine) and advance practice nurse practitioners who elect to be a PCP. All other professional health care providers, including obstetric/gynecology physicians or advance practice nurse practitioners who do not elect to be a PCP, will be deemed to be an SCP
   b. For specialty care providers ("SCP"), the Anthem Rate for the Medicaid Network shall continue in accordance with Provider’s compensation in effect on December 31, 2016 for the applicable provider type ("Fee Schedule") on file with Anthem, as of the effective date of the Medicaid Participation Attachment except for those CPT codes and provider types specifically identified on the attached Medicaid Network Compensation Exhibit A, incorporated herein by reference or
Provider’s billed charge, whichever is less. Payment for Covered Services submitted with the CPT codes or by the provider types set forth on said Exhibit A will be reimbursed based on the Anthem Rate corresponding to the CPT code.

c. For ANCILLARY PROVIDERS/Ancillary Providers, the Anthem Rate for the Medicaid Network shall continue in accordance with ANCILLARY PROVIDER’s/Ancillary Provider’s compensation in effect on December 31, 2016. A copy of the Anthem Rate will be made available upon request. For purposes of this Attachment, subsection d below shall not apply to ANCILLARY PROVIDERS/Ancillary Providers.

d. Upon written notification from the State of Indiana to Anthem of a change in the Fee Schedule, Anthem will have up to ninety (90) days to review the changes in rates, notify Provider and load the new fee schedule into the Anthem Claims system. Anthem shall use best efforts to update the fee schedules as quickly as possible and the changes shall be effective immediately upon such update to the Claims system. In no event shall the effective date of the rate changes extend past the effective date announced by the state or sixty (60) days after the date the state provided the new Fee Schedule to Anthem, whichever is later.

e. Provider agrees that Anthem's payment constitutes payment in full for any Covered Services rendered to Medicaid Covered Individuals. Provider agrees to use best commercial efforts to collect any required copayments for Covered Services rendered to Medicaid Covered Individuals. Provider agrees that, except for copayments set forth in the applicable Health Benefit Plan, it shall not seek payment from the Medicaid Covered Individual or his/her representative. In no event shall Provider seek payment from the State of Indiana for any Health Services rendered pursuant to this Attachment. Medicaid Covered Individuals may not be held liable for any of the following:

i. Any payments for Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the Anthem Rate;

ii. Covered Services provided to the Medicaid Covered Individuals for which OMPP does not pay Anthem;

iii. Covered Services provided to the Medicaid Covered Individuals for which OMPP or Anthem does not pay the Provider that furnishes the services under a contractual, referral or other arrangement;

iv. Anthem's debts in the event of Anthem's insolvency; and

v. Provider may not balance bill Medicaid Covered Individuals, i.e., charge the Medicaid Covered Individuals for Covered Services above the amount paid to Provider by Anthem.

7. Nothing herein shall be construed to prohibit Provider from contracting with other Medicaid managed care organizations.

8. Intentionally left blank

9. Nothing herein will be construed to prohibit or restrict Provider from advising a Medicaid Covered Individual about her/his health status, medical care, or treatment, regardless of whether benefits for such care are available for the Medicaid Covered Individual, if Provider is acting within the lawful scope of practice. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

10. Provider certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Attachment by any federal agency or by any department, agency or political subdivision of the state. For purposes of this Attachment, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Provider's operations. Provider shall immediately notify Anthem if it or any of its principals becomes debarred or suspended, and Anthem shall, at the state's request, take all steps required by the state to terminate its contractual relationship with Provider for work to be performed under this Attachment.
11. Provider agrees to comply with the following:

a. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which Provider receives Federal assistance.

b. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which Provider receives Federal assistance.

c. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which Provider receives Federal assistance.

d. The Americans with Disabilities Act of 1990 (Pub. L. 101-336), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Justice (28 C.F.R. 35.101 et seq.), to the end that in accordance with the Act and Regulation, no person in the United States with a disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Provider receives Federal financial assistance.

e. Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686), and all requirements imposed by or pursuant to regulation, to the end that, in accordance with the Amendments, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Provider receives Federal financial assistance.

f. I.C. 22-9-1-10 and the Civil Rights Act of 1964, as amended, and any other applicable state or federal law, regulations and executive orders prohibiting discrimination, in that Provider shall not discriminate against any employee or applicant for employment in the performance of this Attachment. Provider shall not discriminate with respect to the hire, tenure, terms, conditions or privileges of employment or any matter directly or indirectly related to employment, because of race, color, religion, sex, disability, national origin, ancestry or status as a veteran. Breach of this provision shall be considered default; and

g. All requirements applicable to Provider under the Health Insurance Portability and Accountability Act of 1996.

12. Order of Precedence. All other provisions of the Agreement shall remain in full force and effect. In the event of a) a conflict between the provisions of this Attachment and the Agreement or b) any inconsistency or ambiguity in this Attachment, such conflict, inconsistency or ambiguity shall be resolved by giving precedence in the following order: i) state or federal law, rule, regulation or ordinance; ii) this Attachment; and iii) the Agreement.

13. Notice. Provider shall provide thirty (30) days prior notice of any change in information or status that would affect Medicaid participation or Claims payment status (e.g. change of address, physician status change, etc) to the following address:

Anthem Blue Cross and Blue Shield
Attn: Network Services
P.O. Box 7171
Indianapolis, IN. 40206-7171

14. IHCP providers are prohibited from charging a Medicaid Covered Individual, or the family of the Medicaid
Covered Individual, for any amount not paid as billed for an IHCP Covered Service. Provider acceptance of payment from Anthem as payment in full is a condition of participation in the IHCP. An IHCP provider can bill a Covered Individual only when the following conditions have been met:

a. The service rendered must be determined to be non-covered by Anthem; or

b. The Medicaid Covered Individual has exceeded the program limitations for a particular service; and

c. The Medicaid Covered Individual must understand, before receiving the service, that the service is not covered by Anthem, and that the Medicaid Covered Individual is responsible for the charges associated with the service.

d. The provider must maintain documentation that the Medicaid Covered Individual voluntarily chose to receive the service, knowing that Anthem did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the Medicaid Covered Individual signs the consent before receiving the service. See the IHCP Provider Reference Modules and/or Medicaid Policy Manual for more information.

e. In cases where prior authorization is denied, a provider can bill a Medicaid Covered Individual for services if;

   i. Provider establishes that authorization has been requested and denied prior to rendering the service;

   ii. Provider has an opportunity to request review of the authorization decision by Anthem;

   iii. If authorization is denied upon review, Provider must inform the Medicaid Covered Individual that the service requires authorization, and that authorization has been denied;

   iv. The Medicaid Covered Individual must be informed of the right to contact Anthem to file an appeal if the Medicaid Covered Individual disagrees with the decision to deny authorization;

   v. Provider must inform the Medicaid Covered Individual of his/her responsibility for payment if the Medicaid Covered Individual chooses to or insists on receiving the services without authorization;

   vi. If a waiver is used to establish Medicaid Covered Individual responsibility for payment use of such a waiver must meet the following requirements:

      a. The waiver is signed only after the Medicaid Covered Individual receives the appropriate notification;

      b. The waiver does not contain any language or condition to the effect that if authorization is denied, the Covered Individual is responsible for payment;

      c. 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.

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

15. The following requirements apply solely to PCPs:

   a. PCPs who are not advance nurse practitioners must accept a panel of Medicaid Covered Individuals of at least one hundred (100) individuals. The foregoing does not require PCP to maintain a panel size as indicated, but merely prohibits PCP from closing his/her practice to new Medicaid Covered Individuals unless the panel size is reached. PCP is also not prohibited from accepting more Medicaid Covered Individuals than the indicated panel size. For group practices, the panel size indicated is for each PCP within the group but the total panel is calculated in the aggregate for the group*.
b. PCPs who are advance practice nurse practitioners may not accept a panel size that exceeds five hundred (500) Medicaid enrollees aggregated across all Managed Care Entities. Advance Practice Nurse Practitioner PCPs are responsible for monitoring their total panel size and reporting to Anthem when their panel reaches ninety-five percent (95%) of the maximum.

c. All PCPs must provide or arrange for coverage of services twenty four (24) hours a day, seven (7) days a week;

d. All PCPs must coordinate Medicaid Covered Individual's physical and behavioral health care and make any referrals necessary for services required when Medicaid Covered Individual receives services from any provider other than the PCP unless the service is a self-referral service;

e. All PCPs must have a mechanism in place to offer Medicaid Covered Individuals direct contact with their PCP, or the PCP's qualified clinical staff person, through a toll-free telephone number twenty four (24) hours a day, seven (7) days a week;

f. Each PCP must be available to see Covered Individuals 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;

g. All PCPs must provide "live voice" coverage after normal business hours. After hour coverage for the PCP may include an answering service or a shared-call system with other medical providers.

* Except for Advance Nurse Practitioners acting as group panel size is established on a per PCP basis but calculated in the aggregate for the group. Each PCP in the group is not required to have equal panel size. Thus a panel assignment of one hundred (100) Medicaid Covered Individuals for a group with three (3) PCPs means that the group as a whole must have three hundred (300) Medicaid Covered Individuals before it may close its practice to new Medicaid Covered Individuals. The panel of three hundred (300) Medicaid Covered Individuals may be distributed among the three (3) PCPs in any configuration. All of the following configurations satisfy the requirement for a per PCP panel of one hundred (100) Medicaid Covered Individuals for a group of three (3) PCPs.

<table>
<thead>
<tr>
<th>Ex. A</th>
<th>PCP 1: 100</th>
<th>Ex. B</th>
<th>PCP 1: 150</th>
<th>Ex. C</th>
<th>PCP 1: 300</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP 2: 200</td>
<td>PCP 2: 150</td>
<td>PCP 2: 0</td>
<td>PCP 3: 300</td>
<td>PCP 3: 0</td>
<td>PCP 3: 0</td>
</tr>
</tbody>
</table>
## EXHIBIT A
### MEDICAID NETWORK COMPENSATION

**Effective Date:** January 1, 2017

<table>
<thead>
<tr>
<th>CPT Code*</th>
<th>Anthem Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Evaluation &amp; Management Codes 99281, 99282, 99283, 99284, 99285</td>
<td>The same compensation in effect on December 31, 2016</td>
</tr>
<tr>
<td>Lab Codes for PCPs &amp; SCPs 80047 – 89356</td>
<td>Plan Fee Schedule for the Preferred Provider Organization Network Blue Access/Access</td>
</tr>
<tr>
<td>Drugs billed with J codes for PCPs and SCPs</td>
<td>Reimbursement for drugs billed with J codes will be based on the Indiana Medicare Fee Schedule. Anthem’s reimbursement will adjust as the Indiana Medicare Fee Schedule for these codes adjusts without further notice.</td>
</tr>
<tr>
<td>Advance Practice Nurse Practitioner – PCP</td>
<td>75% of the Anthem Medicaid Fee Schedule - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified. 100% of the Anthem Medicaid Fee Schedule for the following Covered Services billed with the applicable codes: Radiology (70010 – 79999) Pathology and Lab (89357 – 89399) Immunizations (90281-90799) Level II HCPC codes (A0021-A9999, B4034-B9999, C1010-C9711, D0120-D9999, EE0100-E2599, G0001-G9016, K0001-K0620, L0100-L9900, P2028-P9615, Q0035- Q4077, R0070-R0076, and S0012-S9999)</td>
</tr>
<tr>
<td>Advance Practice Nurse Practitioner – SCP - when billing with NPI assigned to Advance Practice Nurse Practitioner.</td>
<td>75% of the Anthem Medicaid Fee Schedule - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified.</td>
</tr>
<tr>
<td>Advance Practice Nurse Practitioner – SCP – employed by Provider and billing with the NPI assigned to a physician with modifier SA</td>
<td>100% of the Anthem Medicaid Fee Schedule - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified.</td>
</tr>
</tbody>
</table>

* Should you require a complete list of codes and reimbursements, please contact your provider representative.
See IHCP bulletin BT201606 for Applied Behavioral Analysis (ABA) Services
Covered ABA Services for Provider Types below: 96150-96155

All other codes will be denied.

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier Required for Provider Type</th>
<th>Provider Type</th>
<th>% of Anthem Rate Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>BCBA, BCBA-D, or HSPP</td>
<td>U1 BCBA, BCBA-D, or HSPP</td>
<td>100%</td>
</tr>
<tr>
<td>U2</td>
<td>BCaBA</td>
<td>U2 BCaBA</td>
<td>100%</td>
</tr>
<tr>
<td>U3</td>
<td>RBT</td>
<td>U3 RBT</td>
<td>75%</td>
</tr>
</tbody>
</table>
This Healthy Indiana Plan Participation Attachment (the "Attachment") is limited to the terms and conditions governing the provision of and payment for Health Services provided to Healthy Indiana Plan enrollees who are also enrolled in the Healthy Indiana Plan managed care program administered by Anthem (hereinafter referred to as "Healthy Indiana Plan Covered Individuals"). Facility agrees to participate as a Network Facility in Anthem’s managed care Healthy Indiana Plan Network (hereinafter "Healthy Indiana Plan Network") and to provide Health Services to Healthy Indiana Plan Covered Individuals. Anthem shall provide notice to Facility if the State of Indiana updates language in the Healthy Indiana Plan Participation Attachment.

2. For purposes of this Attachment, "Healthy Indiana Plan" means the health care coverage plan provided under Indiana House Bill 1678 that extends health care coverage to certain low-income, uninsured Indiana consumers without access to employer sponsored health insurance. For purposes of this Attachment, "Covered Services" means those Medically Necessary Health Services for which a Healthy Indiana Plan Covered Individual is eligible.

3. All of Facility’s duties and obligations to Covered Individuals set forth in the Agreement shall also apply to Healthy Indiana Plan Covered Individuals. In addition, Facility agrees to the following with respect to Healthy Indiana Plan Covered Individuals:

a. Maintain a current Indiana Health Coverage Programs ("IHCP") provider agreement and comply with all IHCP regulations;

b. Maintain medical care standards and practice guidelines as set forth and detailed in the IHCP Provider Reference Modules and/or Medicaid Policy Manual including but not limited to utilizing the Indiana Health Coverage Program Prior Authorization Form available on the Indiana Medicaid website for submission of prior authorization requests to Anthem;

c. Respond to cultural, racial and linguistic needs of Healthy Indiana Plan Covered Individuals;

d. Be duly licensed in accordance with the applicable state licensing board of the State of Indiana. Facility further agrees to remain in good standing with said board;

e. Obtain and maintain all required permits, licenses and approvals and comply with all applicable health, safety and environmental statutes, rules, regulations or ordinances necessary for the performance of Health Services;

f. Comply with the terms applicable to Facility set forth in 1) the Request for Services issued by the State of Indiana in connection with the Healthy Indiana Plan, 2) the managed care organization ("MCO") contract, including incorporated documents, between Anthem and the State of Indiana, which applicable terms are incorporated herein by reference and 3) the Provider Operations Manual. Anthem agrees to provide Facility with a description of the applicable terms in the MCO contract;

g. Comply with all state and federal laws, rules, regulations and ordinances, as amended, applicable to Healthy Indiana Plan Covered Individuals;

h. Cooperate and comply with the Provider Appeals Process as set forth in the Provider Operations Manual for purposes of Claims dispute resolution;

i. Submit all Claims for Health Services rendered to Healthy Indiana Plan Covered Individuals that do not involve a third party payor within ninety (90) days from the date of service. Anthem shall waive the timely filing requirement in the case of Claims for Healthy Indiana Plan Covered Individuals with
retroactive coverage, such as presumptively eligible pregnant women and newborns;

j. Cooperate with any program designed to monitor Healthy Indiana Plan compliance by hospitals who participate in Anthem's Healthy Indiana Plan Network and comply with any corrective actions related thereto if Facility is out of compliance with the Office of Medicaid Policy and Planning ("OMPP") or Anthem's standards;

k. Submit all encounter Claims for Health Services rendered to Healthy Indiana Plan Covered Individuals in accordance with Anthem's specifications for the submission of such encounter data. This provision shall survive termination of this Attachment for services rendered to Healthy Indiana Plan Covered Individuals while Facility is a Network Provider;

l. Provide a copy of a Healthy Indiana Plan Covered Individual's medical record at no charge upon reasonable request by the Healthy Indiana Plan Covered Individual;

m. Facilitate the transfer of the Healthy Indiana Plan Covered Individual's medical record to another hospital at said Healthy Indiana Plan Covered Individual's request, at no charge;

n. Cooperate with and permit evaluations, through on-site inspection or other means, during normal business hours, of the quality, appropriateness, and timeliness of Health Service rendered to Healthy Indiana Plan Covered Individuals. Such evaluations may be conducted by Anthem, OMPP, the Office of Children's Health Insurance Program, the Department of Health and Human Services, or other duly authorized state agency;

o. Cooperate with and permit inspections upon reasonable notice and at reasonable times of any records, medical or financial, pertinent to Facility's delivery of Health Services to Healthy Indiana Plan Covered Individuals. Such inspections may be conducted by Anthem, OMPP, other duly authorized state agency, or their representative;

p. Maintain an adequate record keeping system for recording services, charges, date and other commonly accepted information elements for Health Services rendered to Healthy Indiana Plan Covered Individuals, including, without limitation, the following:

i. Prescriptions for medications;

ii. Inpatient discharge summaries;

iii. Patient histories (including immunizations) and physicals;

iv. A list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs; and

v. A record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and x-ray tests and findings.

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

q. Confidentiality of, and access to, medical records must be provided in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and all other state and federal requirements.

r. Participate in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Anthem for Healthy Indiana Plan Covered Individuals;

s. Observe and protect the rights of Healthy Indiana Plan Covered Individuals;

t. Maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all Facility laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory
testing sites performing Health Services pursuant to this Attachment.

u. Comply with the requirements of 42 CFR 489, Subpart I, related to maintaining and distributing written policies and procedures respecting advance directives;

v. Prepare and submit reports as requested by OMPP or other duly authorized state office (hereinafter "Office") by the completion date established by the Office. Such requests will be limited to situations in which the desired data is considered essential and cannot be reasonably obtained through standard Anthem reports;

w. In the event of Anthem’s insolvency, continue to provide Health Services to Healthy Indiana Plan Covered Individuals until the end of the month in which insolvency has occurred and to provide inpatient Health Services until the date of discharge for any Healthy Indiana Plan Covered Individual institutionalized when insolvency occurs;

x. Maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under this Attachment and make such materials available at the respective offices at all reasonable times during the term of this Attachment, and for three (3) years from the date of final payment under this Attachment, for inspection by the state or its authorized designees. Copies shall be furnished at no cost to the state if requested.

y. Facility shall ask and encourage Healthy Indiana Plan Covered Individuals to sign a consent that permits release of substance abuse treatment information to Anthem and other facilities.

If Facility is a behavioral health facility or providing behavioral health services, the following provisions shall also apply:

a. Facility shall ensure that Healthy Indiana Plan Covered Individuals receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge and that such follow-up and/or continuing treatment is within seven calendar (7) days from the date of the Healthy Indiana Plan Covered Individual's discharge. If the Healthy Indiana Plan Covered Individual misses the follow-up and/or continuing treatment that was scheduled within seven (7) calendar days from the date of the Healthy Plan Covered Individual’s discharge. Facility shall contact the Healthy Plan Covered Individual within three (3) business days of the notification of the missed appointment.

aa. Facility shall notify Anthem and the Healthy Indiana Plan Covered Individual's PCP within five (5) days of an Anthem enrolled Healthy Indiana Plan Covered Individual's visit, and submit the following information to Anthem and the Healthy Indiana Plan Covered Individual's Primary Care Provider ("PCP") about the treatment plan, the diagnosis and medications including but not limited to:

i. A written summary of the initial assessment session;
ii. Primary and secondary diagnoses;
iii. Medication prescribed
iv. Psychotherapy prescribed;
v. Any other relevant information.

bb. Facility shall notify Anthem and the Healthy Indiana Plan Covered Individual's PCP of any significant changes in the Healthy Indiana Plan Covered Individual's status and/or a change in the level of care.

4. Termination of Healthy Indiana Plan Network Attachment.

a. This Attachment shall automatically terminate upon the occurrence of any one of the following:

i. Termination of Facility's license;
ii. Termination of Facility's IHCP hospital agreement;
iii. Failure to comply with section 3.g above;
iv. Termination/expiration of Anthem's Healthy Indiana Plan MCO contract with the State of Indiana in accordance with IC 12-15-30-5;

v. Failure to meet OMPP's or Anthem's credentialing standards for the Healthy Indiana Plan Network;

vi. Failure to meet OMPP's access and availability standards;

vii. Facility's exclusion from participation in Federal health care programs under Section 1128 or Section 1128A of the Social Security Act; or

viii. Failure to meet other quality improvement program standards.

b. Either party hereto may terminate this Attachment without cause upon one hundred and eighty (180) days prior written notice to the other party without affecting the Agreement, amendments, addenda, or other attachments, or Facility's participation in other Network(s).

c. If either party fails to comply with or perform any term or condition of this Attachment, the other party shall notify the defaulting party of its default in writing, and the defaulting party shall have thirty (30) days to cure the default. If the default is not cured within said thirty (30) day period, this Attachment is automatically terminated, unless otherwise specified by the non-defaulting party.

5. This Attachment shall be automatically amended to conform to applicable changes to state or federal laws, rules, regulations or ordinances related to Healthy Indiana Plan Covered Individuals or the Healthy Indiana Plan without the necessity of executing written amendments.


a. Except as otherwise set forth herein, the Anthem Rate is based on one hundred percent (100%) of the State of Indiana Medicare Fee Schedule or one hundred thirty percent (130%) of the Indiana Medicaid Fee Schedule if the service does not have a Medicare reimbursement rate (collectively referred to herein as the "Fee Schedule") on file with Anthem, as of the effective date of the Healthy Indiana Plan Participation Attachment or Facility's billed charge, whichever is less except for those Revenue Codes specifically identified on the attached Healthy Indiana Plan Network Compensation Exhibit A, incorporated herein by reference.

i. Payment for Covered Services submitted with the Revenue Codes set forth on said Exhibit A will be reimbursed based on the Anthem Rate corresponding to the Revenue Code.

ii. Facility acknowledges that reimbursement for some Covered Services may first be made from the Healthy Indiana Plan Covered Individual's POWER Account, with any remaining balance payable as set forth in this Attachment.

iii. Facility agrees that under no circumstances shall it balance bill the Healthy Indiana Plan Covered Individual for amounts exceeding the Anthem Rate.

iv. For purposes of this Attachment, "POWER Account" means an individual health care account funded by, at minimum, the State of Indiana and the Healthy Indiana Plan Covered Individual and used by that Healthy Indiana Plan Covered Individual to purchase Covered Services before their deductible is met.

v. For certain types of Healthy Indiana Plan Covered Individuals as defined by OMPP, rates are based on one hundred percent (100%) of the Indiana Medicaid Fee Schedule and Facility shall receive additional compensation as determined by OMPP within thirty (30) days of Anthem's receipt of such additional compensation from OMPP. This additional compensation is calculated by OMPP and is based upon the Hospital Assessment Fee ("HAF") as set forth in the IHCP Provider Reference Modules and/or Medicaid Policy Manual.

b. The Medicare Fee Schedule and the Medicaid Fee Schedule are intended to include such reimbursement policies and procedures such as "never event" and "hospital acquired condition" payment practices in accordance with 405 IAC 1-10.5-5 and applicable current Medicare National
Coverage Determinations.

c. Upon notice of any changes to the Fee Schedule, Anthem reserves the right to review, accept and implement such change before it shall be deemed effective. Anthem will notify Facility in writing of the new rates and effective date according to the Notice section of the Agreement.

d. Facility agrees that the Anthem Rate constitutes payment in full for any Covered Services rendered to Healthy Indiana Plan Covered Individuals. Facility agrees to use best commercial efforts to collect required copayments for Covered Services rendered to applicable Healthy Indiana Plan Covered Individuals. Facility agrees that, except for copayments set forth in the applicable Health Benefit Plan, it shall not seek payment from the Healthy Indiana Plan Covered Individual, his/her representative or the State of Indiana for any Health Services rendered pursuant to this Attachment. Healthy Indiana Plan Covered Individuals may not be held liable for any of the following:

i. Any payments for Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the Anthem Rate.

ii. Covered Services provided to the Health Indiana Plan Covered Individuals for which OMPP does not pay Anthem;

iii. Covered Services provided to the Healthy Indiana Plan Covered Individuals for which OMPP or Anthem does not pay the Facility that furnishes the services under a contractual, referral or other arrangement;

iv. Anthem's debts in the event of Anthem's insolvency; and

v. Facility may not balance bill Healthy Indiana Plan Covered Individuals (i.e., charge the Healthy Indiana Plan Covered Individuals for Covered Services above the amount paid to Facility by Anthem).

7. Nothing herein shall be construed to prohibit Facility from contracting with other Healthy Indiana Plan managed care organizations.

8. Facility shall be compensated pursuant to the amounts specified herein. Facility acknowledges that Healthy Indiana Plan Covered Individuals shall have access to Facility's rates. Such rates, as well as quality information regarding Facility, may be made available on Anthem's member web site.

9. Nothing herein will be construed to prohibit or restrict Facility from advising a Healthy Indiana Plan Covered Individual about his/her health status, medical care, or treatment, or the risks, benefits and consequences of treatment or non-treatment, regardless of whether benefits for such care are available for the Healthy Indiana Plan Covered Individual, if Facility is acting within the lawful scope of practice. However, this provision does not require Facility to provide Health Services if Facility objects to such service on moral or religious grounds.

10. Facility certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Attachment by any Federal agency or by any department, agency or political subdivision of the state. Facility shall immediately notify Anthem if it or any of its principals becomes debarred or suspended, and Anthem shall, at the state's request, take all steps required by the state to terminate its contractual relationship with Facility for work to be performed under this Attachment. For purposes of this Attachment, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Facility's operations.

11. Facility agrees to comply with the following:

a. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the regulation of the Department of Health and Human Services (45 CFT Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or
activity for which Facility receives Federal assistance.

b. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which Facility receives Federal assistance.

c. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which Facility receives Federal assistance.

d. The Americans with Disabilities Act of 1990 (Pub. L. 101-336), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Justice (28 CFR 35.101 et seq.), to the end that in accordance with the Act and Regulation, no person in the United States with a disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Facility receives Federal financial assistance.

e. Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686), and all requirements imposed by or pursuant to regulation, to the end that, in accordance with the Amendments, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Facility receives Federal financial assistance.

f. I.C. 22-9-1-10 and the Civil Rights Act of 1964, as amended, and any other applicable state or federal law, regulations and executive orders prohibiting discrimination, in that Facility shall not discriminate against any employee or applicant for employment in the performance of this Attachment. Facility shall not discriminate with respect to the hire, tenure, terms, conditions or privileges of employment or any matter directly or indirectly related to employment, because of race, color, religion, sex, disability, national origin, ancestry or status as a veteran. Breach of this provision shall be considered default; and

g. All requirements applicable to Facility under the Health Insurance Portability and Accountability Act of 1996.

12. Order of Precedence. All other provisions of the Agreement shall remain in full force and effect. In the event of a) a conflict between the provisions of this Attachment and the Agreement, or b) any inconsistency or ambiguity in this Attachment, such conflict, inconsistency or ambiguity shall be resolved by giving precedence in the following order: i) state or federal law, rule, regulation or ordinance; ii) this Attachment; and iii) the Agreement.

13. Notice. Facility shall provide thirty (30) days prior notice of any change in information or status that would affect Healthy Indiana Plan Network participation or Claims payment status (e.g. change of address, physician status change, etc) to the following address:

Anthem Blue Cross and Blue Shield
Attn: Network Services
PO Box 7171
Indianapolis, IN 46207-7171

14. IHCP facilities are prohibited from charging a Healthy Indiana Plan Covered Individual, or the family of the Healthy Indiana Plan Covered Individual, for any amount not paid as billed for a covered IHCP Covered Service. Facility acceptance of payment from Anthem as payment in full is a condition of participation in the IHCP. An IHCP facility can bill a Covered Individual only when the following conditions have been met:

a. The service rendered must be determined to be non-covered by Anthem; or

b. The Healthy Indiana Plan Covered Individual has exceeded the program limitations for a particular service; and
c. The Healthy Indiana Plan Covered Individual must understand, before receiving the service, that the service is not covered by Anthem, and that the Healthy Indiana Plan Covered Individual is responsible for the charges associated with the service.

d. The facility must maintain documentation that the Healthy Indiana Plan Covered Individual voluntarily chose to receive the service, knowing that Anthem did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the Healthy Indiana Plan Covered Individual signs the consent before receiving the service. See the IHCP Provider Reference Modules and/or Medicaid Policy Manual for more information.

e. In cases where prior authorization is denied, a facility can bill a Healthy Indiana Plan Covered Individual for services if;

i. Facility establishes that authorization has been requested and denied prior to rendering the service:

ii. Facility has the opportunity to request review of the authorization decision by Anthem;

iii. If authorization is denied upon review, facility must inform the Healthy Indiana Plan Covered Individual that the service requires authorization, and that authorization has been denied;

iv. The Healthy Indiana Plan Covered Individual must be informed of the right to contact Anthem to file an appeal if the Healthy Indiana Plan Covered Individual disagrees with the decision to deny authorization;

v. Facility must inform the Healthy Indiana Plan Covered Individual of his/her responsibility for payment if the Healthy Indiana Plan Covered Individual chooses to or insists on receiving the services without authorization;

vi. If a waiver is used to establish Healthy Indiana Plan Covered Individual responsibility for payment, use of such a waiver must meet the following requirements:

a. The waiver is signed only after the Healthy Indiana Plan Covered Individual receives the appropriate notification;

b. The waiver does not contain any language or condition to the effect that if authorization is denied, Covered Individual is responsible for payment;

c. Facility 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; and

d. The waiver must specify the date the services are provided and the services that fall under the waiver's application.
<table>
<thead>
<tr>
<th>Billing Codes:</th>
<th>Revenue Code: 513</th>
<th>CPT Code: T1015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Rate:</td>
<td>$70.00</td>
<td></td>
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Revenue Code 513 applies to Behavioral Health Services only.
This is a Participation Attachment to the Anthem Blue Cross and Blue Shield HOSPITAL/Facility Agreement (the "Agreement") as applicable, entered into by and between Anthem and HOSPITAL/Facility and is incorporated into the Agreement. For purposes of this Attachment all references to Facility shall encompass HOSPITAL and all references to Anthem shall also encompass ANTHEM as well.

1. This Medicaid Participation Attachment (the "Attachment") is limited to the terms and conditions governing the provision of and payment for Health Services provided to Medicaid enrollees who are also enrolled in Anthem's managed care Medicaid program (hereinafter referred to as "Medicaid Covered Individuals"). Facility agrees to participate as a Network Facility in Anthem's managed care Medicaid Network (hereinafter "Medicaid Network") and to provide Health Services to Medicaid Covered Individuals. Anthem shall provide notice to Facility if the State of Indiana updates language in the Medicaid Participation Attachment.

2. For purposes of this Attachment, "Medicaid" means medical assistance provided under a state plan approved under Title XIX of the Social Security Act. For purposes of this Attachment, "Covered Services" means those Medically Necessary Health Services for which a Medicaid Covered Individual is eligible.

3. All of Facility's duties and obligations to Covered Individuals set forth in the Agreement shall also apply to Medicaid Covered Individuals. In addition, Facility agrees to the following with respect to Medicaid Covered Individuals:
   a. Maintain a current Indiana Health Coverage Programs ("IHCP") provider agreement and comply with all IHCP regulations;
   b. Maintain medical care standards and practice guidelines as set forth and detailed in the IHCP Provider Reference Modules and/or Medicaid Policy Manual including but not limited to utilizing the Indiana Health Coverage Program Prior Authorization Form available on the Indiana Medicaid website for submission of prior authorization requests to Anthem;
   c. Respond to cultural, racial and linguistic needs of Medicaid Covered Individuals;
   d. Be duly licensed in accordance with the applicable state licensing board of the State of Indiana. Facility further agrees to remain in good standing with said board;
   e. Obtain and maintain all required permits, licenses and approvals and comply with all applicable health, safety and environmental statutes, rules, regulations or ordinances necessary for the performance of Health Services;
   f. Comply with the terms applicable to Facility set forth in 1) the Request for Services issued by the State of Indiana in connection with the Medicaid program, 2) the managed care organization ("MCO") contract, including incorporated documents, between Anthem and the State of Indiana, which applicable terms are incorporated herein by reference and 3) the Provider Operations Manual. Anthem agrees to provide Facility with a description of the applicable terms in the MCO contract;
   g. Comply with all state and federal laws, rules, regulations and ordinances, as amended, applicable to Medicaid Covered Individuals;
   h. Cooperate and comply with the Provider Appeals Process as set forth in the Provider Operations Manual for purposes of Claims dispute resolution;
   i. Submit all Claims for Health Services rendered to Medicaid Covered Individuals that do not involve a third party payor within ninety (90) days from the date of service. Anthem shall waive the timely filing requirement in the case of Claims for Medicaid Covered Individuals with retroactive coverage, such as presumptively eligible pregnant women and newborns;
   j. Cooperate with any program designed to monitor Medicaid program compliance by hospitals who participate in Anthem's Medicaid Network and comply with any corrective actions related thereto if
Facility is out of compliance with the Office of Medical Policy and Planning ("OMPP") or Anthem's standards;

k. Submit all encounter Claims for Health Services rendered to Medicaid Covered Individuals in accordance with Anthem's specifications for the submission of such encounter data; This provision shall survive termination of this Attachment for services rendered to Medicaid Covered Individuals while Facility is a Network Provider;

l. Provide a copy of a Medicaid Covered Individual's medical record at no charge upon reasonable request by the Medicaid Covered Individual;

m. Facilitate the transfer of the Medicaid Covered Individual's medical record to another hospital at said Medicaid Covered Individual's request, at no charge;

n. Cooperate with and permit evaluations, through on-site inspection or other means, during normal business hours, of the quality, appropriateness, and timeliness of Health Service rendered to Medicaid Covered Individuals. Such evaluations may be conducted by Anthem, The Office of Medicaid Policy and Planning ("OMPP"), the Office of Children's Health Insurance Program, the Department of Health and Human Services, or other duly authorized state agency;

o. Cooperate with and permit inspections upon reasonable notice and at reasonable times of any records, medical or financial, pertinent to Facility's delivery of Health Services to Medicaid Covered Individuals. Such inspections may be conducted by Anthem, OMPP, the Office of Children's Health Insurance Program, or other duly authorized state agency, or their representative;

p. Maintain an adequate record keeping system for recording services, charges, date and other commonly accepted information elements for Health Services rendered to Medicaid Covered Individuals, including, without limitation, the following:

i. Prescriptions for medications;

ii. Inpatient discharge summaries;

iii. Patient histories (including immunizations) and physicals;

iv. A list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs; and

v. A record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and x-ray tests and findings.

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

q. Confidentiality of, and access to, medical records must be provided in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and all other state and federal requirements.

r. Participate in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Anthem for Medicaid Covered Individuals;

s. Observe and protect the rights of Medicaid Covered Individuals;

t. Maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all Facility laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment;

u. Comply with the requirements of 42 CFR 489, Subpart I, related to maintaining and distributing written policies and procedures respecting advance directives;
v. Prepare and submit reports as requested by the OMPP or the Office of Children's Health Insurance Program (hereinafter "Offices") by the completion date established by either of the Offices. Such requests will be limited to situations in which the desired data is considered essential and cannot be reasonably obtained through standard Anthem reports;

w. In the event of Anthem's insolvency, continue to provide Health Services to Medicaid Covered Individuals until the end of the month in which insolvency has occurred and to provide inpatient Health Services until the date of discharge for any Medicaid Covered Individual institutionalized when insolvency occurs.

x. Maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under this Attachment and make such materials available at the respective offices at all reasonable times during the term of this Attachment, and for three (3) years from the date of final payment under this Attachment, for inspection by the state or its authorized designees. Copies shall be furnished at no cost to the state if requested.

y. Facility shall ask and encourage Medicaid Covered Individuals to sign a consent that permits release of substance abuse treatment information to Anthem and other facilities.

If Facility is a behavioral health facility or providing behavioral health services, the following provisions shall also apply:

a. Facility shall ensure that Medicaid Covered Individuals receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge and that such follow-up and/or continuing treatment is within seven (7) calendar days from the date of the Medicaid Covered Individual's discharge. If the Medicaid Covered Individual misses the follow-up and/or continuing treatment that was scheduled within seven (7) calendar days from the date of the Medicaid Covered Individual's discharge. Facility shall contact the Medicaid Covered Individual within three (3) business days of the notification of the missed appointment.

aa. Facility shall notify Anthem and the Medicaid Covered Individual's PCP within five (5) days of an Anthem enrolled Medicaid Covered Individual's visit, and submit the following information to Anthem and the Medicaid Covered Individual's Primary Care Provider ("PCP") about the treatment plan, the diagnosis and medications including but not limited to:
   i. A written summary of the initial assessment session;
   ii. Primary and secondary diagnoses;
   iii. Medication prescribed
   iv. Psychotherapy prescribed;
   v. Any other relevant information.

bb. Facility shall notify Anthem and the Medicaid Covered Individual's PCP of any significant changes in the Medicaid Covered Individual's status and/or a change in the level of care.

4. Termination of Medicaid Network Attachment.

a. This Attachment shall automatically terminate upon the occurrence of any one of the following:

   i. Termination of Facility's license;
   ii. Termination of Facility's IHCP hospital agreement;
   iii. Failure to comply with section 3. g. above;
   iv. Termination/expiration of Anthem's Medicaid MCO contract with the State of Indiana in accordance with IC 12-15-30-5;
   v. Failure to meet OMPP's or Anthem's credentialing standards for the Medicaid Network;
   vi. Failure to meet OMPP's access and availability standards;
vii. Facility's exclusion from participation in Federal health care programs under Section 1128 or Section 1128A of the Social Security Act; or

viii. Failure to meet other quality improvement program standards.

b. Either party hereto may terminate this Attachment without cause upon one hundred eighty (180) days prior written notice to the other party without affecting the Agreement, amendments, addenda, or other attachments, or Facility's participation in other Network(s).

c. If either party fails to comply with or perform any term or condition of this Attachment, the other party shall notify the defaulting party of its default in writing, and the defaulting party shall have thirty (30) days to cure the default. If the default is not cured within said thirty (30) day period, this Attachment is automatically terminated, unless otherwise specified by the non-defaulting party.

5. This Attachment shall be automatically amended to conform to applicable changes to state or federal laws, rules, regulations or ordinances related to Medicaid Covered Individuals or the Indiana Medicaid program without the necessity of executing written amendments.


a. The Anthem Rate is based on one hundred percent (100%) of the State of Indiana Medicaid Fee Schedule ("Fee Schedule") on file with Anthem, as of the effective date of the Medicaid Participation Attachment except for those Revenue Codes specifically identified on the attached Medicaid Network Compensation Exhibit A, incorporated herein by reference or Facility's billed charge, whichever is less. Payment for Covered Services submitted with the Revenue Codes set forth on said Exhibit A will be reimbursed based on the Anthem Rate corresponding to the Revenue Code.

b. Subject to the provisions below, for Inpatient Services and Ambulatory Surgery Services rendered on or after the Effective Date of this Attachment, reimbursement by Anthem shall be at the current Fee Schedule then in effect in the applicable geographic region, or Facility's actual billed charges, whichever is lesser, as payment in full for all Covered Services provided to Covered Individuals.

c. The Fee Schedule is intended to include such reimbursement policies and procedures such as "never event" and "hospital acquired condition" payment practices in accordance with 405 IAC 1-10.5-5 and any other applicable guidance from the state.

d. Upon written notification from the State of Indiana to Anthem of a change in the Fee Schedule, Anthem will have up to ninety (90) days to review the changes in rates, notify Facility and load the new fee schedule into the Anthem claims system (the "Implementation Date"). The effective date of the rate change will be concurrent with the date announced by the state or the date the state provided the new Fee Schedule to Anthem whichever is later.

e. Notwithstanding the effective date announced by the state, Facility and Anthem agree that Anthem will not be required to reprocess Claims submitted by Facility prior to the Implementation Date in accordance with the new Fee Schedule.

f. In lieu of Claims reprocessing, a settlement process may be used to compare the total amount of payments that would have been paid under the new fees to the actual payments. The difference between these amounts shall constitute the settlement amount due between the parties. Facility shall submit a list of Claims paid at the prior Fee Schedule but subject to the new Fee Schedule within one hundred eighty (180) days of the Implementation Date. Failure to provide such a list of Claims within one hundred eighty (180) days of the Implementation Date shall relieve Anthem of any obligation to pay any difference in reimbursement.

7. Facility agrees the Anthem Rate constitutes payment in full for any Covered Services rendered to Medicaid Covered Individuals. Facility agrees that, except for copayments set forth in the applicable Health Benefit Plan, it shall not seek payment from the Medicaid Covered Individual, his/her representative or the State of Indiana for any Health Services rendered pursuant to this Attachment. Medicaid Covered Individuals may not be held liable for any of the following:

a. Any payments for Covered Services furnished under a contract, referral or other arrangement, to
the extent that those payments are in excess of the Anthem Rate;

b. Covered Services provided to the Medicaid Covered Individuals for which OMPP does not pay Anthem;

c. Covered Services provided to the Medicaid Covered Individuals for which OMPP or Anthem does not pay the Facility that furnishes the services under a contractual, referral or other arrangement;

d. Anthem's debts in the event of Anthem's insolvency; and

e. Facility may not balance bill Medicaid Covered Individuals (i.e., charge the Medicaid Covered Individuals for Covered Services above the amount paid to Facility by Anthem).

8. Nothing herein shall be construed to prohibit Facility from contracting with other Medicaid managed care organizations.

9. Intentionally left blank.

10. Nothing herein will be construed to prohibit or restrict Facility from advising a Medicaid Covered Individual about his/her health status, medical care, or treatment, or the risks, benefits and consequences of treatment or non-treatment, regardless of whether benefits for such care are available for the Medicaid Covered Individual, if Facility is acting within the lawful scope of practice. However, this provision does not require Facility to provide Health Services if Facility objects to such service on moral or religious grounds.

11. Facility certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Attachment by any Federal agency or by any department, agency or political subdivision of the state. Facility shall immediately notify Anthem if it or any of its principals becomes debarred or suspended, and Anthem shall, at the state's request, take all steps required by the state to terminate its contractual relationship with Facility for work to be performed under this Attachment. For purposes of this Attachment, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Facility's operations.

12. Facility agrees to comply with the following:

a. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which Facility receives Federal assistance.

b. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which Facility receives Federal assistance.

c. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which Facility receives Federal assistance.

d. The Americans with Disabilities Act of 1990 (Pub. L. 101-336), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Justice (28 C.F.R. 35.101 et seq.), to the end that in accordance with the Act and the Regulation, no person in the United States with a disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Facility receives Federal financial assistance.

e. Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and
1685-1686), and all requirements imposed by or pursuant to regulation, to the end that, in accordance with the Amendments, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Facility receives Federal financial assistance.

f. I.C. 22-9-1-10 and the Civil Rights Act of 1964, as amended, and any other applicable state or federal law, regulations and executive orders prohibiting discrimination, in that Facility shall not discriminate against any employee or applicant for employment in the performance of this Attachment. Facility shall not discriminate with respect to the hire, tenure, terms, conditions or privileges of employment or any matter directly or indirectly related to employment, because of race, color, religion, sex, disability, national origin, ancestry or status as a veteran. Breach of this provision shall be considered default; and

g. All requirements applicable to Facility under the Health Insurance Portability and Accountability Act of 1996.

13. Order of Precedence. All other provisions of the Agreement shall remain in full force and effect. In the event of a) a conflict between the provisions of this Attachment and the provisions of the Agreement or b) any inconsistency or ambiguity in this Attachment, such conflict, inconsistency or ambiguity shall be resolved by giving precedence in the following order: i) state or federal law, rule, regulation or ordinance; ii) this Attachment; and iii) the Agreement.

14. Notice. Facility shall provide thirty (30) days prior notice of any change in information or status that would affect Medicaid participation or Claims payment status (e.g. change of address, physician status change, etc) to the following address:

Anthem Blue Cross and Blue Shield
Attn: Network Services
P.O. Box 7171
Indianapolis, IN. 40206-7171

15. IHCP facilities are prohibited from charging a Medicaid Covered Individual, or the family of the Medicaid Covered Individual, for any amount not paid as billed for a covered IHCP Covered Service. Facility acceptance of payment from Anthem as payment in full is a condition of participation in the IHCP. An IHCP facility can bill a Covered Individual only when the following conditions have been met:

a. The service rendered must be determined to be non-covered by Anthem; or

b. The Medicaid Covered Individual has exceeded the program limitations for a particular service; and

c. The Medicaid Covered Individual must understand, before receiving the service, that the service is not covered by Anthem, and that the Medicaid Covered Individual is responsible for the charges associated with the service.

d. The facility must maintain documentation that the Medicaid Covered Individual voluntarily chose to receive the service, knowing that Anthem did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the Medicaid Covered Individual signs the consent before receiving the service. See the IHCP Provider Reference Modules and/or Medicaid Policy Manual for more information.

e. In cases where prior authorization is denied, a facility can bill a Medicaid Covered Individual for services if;

i. Facility establishes that authorization has been requested and denied prior to rendering the service;

ii. Facility has the opportunity to request review of the authorization decision by Anthem;

iii. If authorization is denied upon review, facility must inform the Medicaid Covered Individual that the service requires authorization, and that authorization has been denied;

iv. The Medicaid Covered Individual must be informed of the right to contact Anthem to file an
appeal if the Medicaid Covered Individual disagrees with the decision to deny authorization;

v. Facility must inform the Medicaid Covered Individual of his/her responsibility for payment if the Medicaid Covered Individual chooses to or insists on receiving the services without authorization;

vi. If a waiver is used to establish Medicaid Covered Individual responsibility for payment use of such a waiver must meet the following requirements:

   a. The waiver is signed only after the Medicaid Covered Individual receives the appropriate notification;

   b. The waiver does not contain any language or condition to the effect that if authorization is denied, the Covered Individual is responsible for payment;

   c. Facility 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; and

   d. The waiver must specify the date the services are provided and the services that fall under the waiver's application.
## EXHIBIT A
### MEDICAID NETWORK COMPENSATION

<table>
<thead>
<tr>
<th>Billing Codes:</th>
<th>Revenue Code: 513</th>
<th>CPT Code: T1015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Rate:</td>
<td>$70.00</td>
<td></td>
</tr>
</tbody>
</table>

Revenue Code 513 applies to Behavioral Health Services only.