TERM SHEET

THIS TERM SHEET ("Term Sheet") is made and entered into this 9th day of MAY, 2014, by and between the State of Indiana ("State") by and through the Office of Management and Budget ("OMB") and the Indiana Hospital Association, Inc. ("IHA") (collectively, the "Parties").

RECITALS

- The Parties have had discussions regarding a possible HIP expansion. These discussions, which have been constructive and collaborative in nature, have included the possible use of Indiana's hospital assessment fee to help fund the HIP expansion, as well as other matters relevant to coverage expansion.

- The Parties wish to state herein their mutual good faith intentions with regard to HIP expansion.

- The Parties acknowledge that the intentions expressed in this Term Sheet are contingent upon federal approval of the Waiver, as defined in Section 2, as well as any State Plan amendments needed to effectuate the Waiver.

- The Parties understand and agree that this Term Sheet evidences the good faith mutual intentions of the Parties regarding a possible HIP expansion, and that nothing in this Term Sheet is to be construed as a binding agreement between the State and IHA.

STATEMENT OF MUTUAL INTENTIONS

The following are the Parties' mutual good faith intentions with regard to coverage expansion through HIP:

1. Applicability. This Term Sheet pertains to the Section 1115 demonstration waiver for the expansion of HIP that the State is currently negotiating with CMS.

2. Definitions. The following definitions apply throughout this Term Sheet:

(A) "Committee" means the Hospital Assessment Fee Committee as established pursuant IC 16-21-10-7.

(B)"HAF" means the hospital assessment fee that is established and implemented pursuant to IC 16-21-10.

(C) "HCI" means the hospital care for the indigent program, established pursuant to IC 12-16-7.5.

(D) "HIP" means Indiana's Healthy Indiana Plan, established and implemented pursuant to IC 12-15-44.2.

(E) "HIP 2.0" means the State's health care plan to expand HIP to capitalize on the enhanced federal Medicaid match rates in 42 U.S.C. § 1396d(y)(1) and to provide healthcare coverage to the HIP 2.0 Population pursuant to the terms and conditions of a Section 1115 demonstration waiver.

(F) "HIP 2.0 Population" means all uninsured, non-disabled adults between 19 and 64 years of age with family income up to and including 133% of the federal poverty level under the modified adjusted gross income standards (effectively 138% of federal poverty level following the 5% income disregard)qualifying for HIP 2.0, as established pursuant to the terms and conditions of a Section 1115 demonstration waiver.

(G) "HIP Trust Fund" means the Indiana check-up trust fund established by IC 12-15-44.2-17.

(H) "Hoosier Healthwise" means the State's current healthcare program for children, pregnant women, and low-income families.

I) "Hospital" means a hospital licensed under IC 16-21-2 or a private mental health institution licensed under IC 12-25.

(J) "IMD" means an Institution for Mental Health Diseases.

(K) "IMD Exclusion" means the federal policy that generally prohibits direct Medicaid reimbursement for care provided in an IMD to individuals between 21 and 65 years of age.

(L) "MCE" means a managed care entity contracted by the State to provide services to the HIP 2.0 Population.

(M) "Medicare Rates" means:

(i) for hospital services, Medicare equivalent reimbursement rates for such services as calculated under the HAF program; and

(ii) for services provided by non-hospital health care providers eligible for reimbursement under HIP 2.0, the Medicare reimbursement rates for such services, or rates equal to 130% of the Medicaid reimbursement rates for such services that do not have Medicare reimbursement rates.

(N) "Physician Services" shall include services provided by physicians (both general practitioners and specialists), nurse practitioners, and other similar professionals.

(O) "State Share" means the State's share of HIP 2.0 expenses, which share is the amount remaining after the enhanced federal Medicaid match rate provided for in the current version of 42 U.S.C. § 1396d(y)(1) for the subject calendar year is applied to the expense (unless expressly stated otherwise in this Term Sheet).

(P) "Waiver" means the Section 1115 demonstration waiver granted by CMS to the State for purposes of implementing HIP 2.0.

3. Start Date. Given the nature of the federal waiver approval process, the State is unable to commit to a firm HIP 2.0 implementation date. However, the State will make every commercially reasonable effort to implement HIP 2.0 as soon as practicable on or after January 1, 2015.

4. Use of Cigarette Tax.

(A) The current balance in the HIP Trust Fund (approximately $338 million) will be used by the State to fund only:

(i) HIP 2.0 expenses in excess of other available funding sources in any given calendar year; and

(ii) HIP 2.0 expenses incurred by the State during a phase-out of the Waiver.

Nothing herein shall be construed to restrict the State's ability to utilize the HIP Trust Fund to continue to pay for the annual operating costs of the current HIP program under IC 12-15-44-2 that are incurred in the normal course of the program's operation.

(B) Subject to (A) above, the entirety of the annual cigarette tax collections dedicated to the HIP Trust Fund under IC 6-7-1-28.1(5) will be used to fund the State Share amounts listed in Paragraphs (i) through (iii) of Section 5(B) of this Term Sheet.

(C) For each state fiscal year (SFY) of HIP 2.0, the total amount of HAF funds used to fund the State Share amounts listed in Section 5 below will be reduced by the amount of annual cigarette tax collections described in Subsection (B) above.

5. HAF Funding for HIP 2.0 Expenses.

(A) For SFYs 2015 and 2016, no HAF funds will be used to fund HIP 2.0 expenses.

(B) With regard to the HIP 2.0 (and also the State Share amounts described in Paragraph (ii) of this Subsection (B)), the HAF, subject to Subsection (A) of this Section 5 and Section 7(B), will be used to fund only the following expenses:

(i) State Share of payments to support HIP 2.0. The HAF will fund the following State Share of payments related to the operation of HIP 2.0:

(a) 100% of the State Share of the capitated payments made to the MCEs for costs related to the provision of health care services provided to HIP 2.0 enrollees at Medicare Rates. Notwithstanding the foregoing, for HIP 2.0 parents and caretaker enrollees previously ineligible for HIP pursuant to Section 1931 of the Social Security Act, HAF payments towards the MCE capitation payment shall be limited to the difference between the Hoosier Healthwise capitation rate and the HIP 2.0 capitation rate attributed to the difference between Medicare reimbursement rates and the 2014 Medicaid reimbursement rates.

(b) the State Share of contributions to POWER Account for all HIP 2.0 enrollees, at applicable federal matching rates; and

(c) the State Share of amounts used to pay premiums for the HIP Employer Benefit Link, an optional defined contribution premium assistance program.

(ii) State Share of payments for Physician Services for Non-HIP 2.0 Medicaid programs. The HAF will fund the State Share (based on the "regular" federal Medicaid match rate) of payments as described in this Paragraph (ii) for covered Physician Services provided to individuals enrolled in other non-HIP 2.0 Medicaid programs, including, Hoosier Healthwise, programs for the aged, blind and disabled, and Medicaid fee for service. For purposes of this Paragraph (ii), such payments will be equal to the difference between:

(a) the Medicaid fee schedule amount (the State agrees not to reduce this fee schedule amount while HIP 2.0 is in effect) for the physician service; and

(b) the amount that is 75% of the Medicare Rate for such service.

(iii) State Share of Administrative Costs. The HAF will fund the State Share (based on the applicable federal Medicaid match rates) of HIP 2.0's administrative costs, which will be limited to $170 per person enrolled in HIP 2.0, per year, increasing annually by the consumer price index.

(C) The Hospital's obligation to fund HIP 2.0 expenses pursuant to this Section 5 shall immediately cease upon the State's written notice to CMS of the State's decision to terminate the Waiver for any reason.

6. HCI Funds. The Parties mutually agree to pursue elimination of the HCI appropriations used for purposes of IC 16-21-10-10 for SFYs 2017 and after, and for so long as the Waiver is in effect. Nothing in this Term Sheet applies to IC 12-16-17 and the funding provided for therein. To clarify, it is the intent of the Parties not to pursue appropriations of HCI funds used for purposes of IC 16-21-10-10 ($27.5 million per SFY); however, the Parties acknowledge that only the General Assembly has the authority to appropriate funds. Further, IHA expressly agrees not to pursue legislation or to otherwise lobby to obtain HCI appropriations (except for purposes of IC 12-16-17) beyond SFY 2017 for so long as the Waiver is in effect.

7. Funding of Phase-Out Expenses.

(A) HAF funds described in Subsection (B) of this Section 7 will be deposited into the HIP Trust Fund and will remain a part of the HIP Trust Fund, but will be separately accounted for, and utilized only for the purposes described in this Section 7. Interest accruing on the HAF funds deposited in the HIP Trust Fund will remain in the HIP Trust Fund, and shall be credited to the Hospitals' pro rata portion of the HIP Trust Fund upon the termination of the program pursuant to this Section 7.

(B) HAF funds totaling eleven million five hundred thousand dollars ($11.5 million) will be deposited into the HIP Trust Fund on an annual basis for SFY 2017, SFY 2018, SFY 2019, and SFY 2020. Upon the State's written notice to CMS of the State's decision to terminate the Waiver for any reason, the Hospitals' obligation to pay the HAF funding of the HIP Trust Fund shall immediately cease. However, funds previously deposited into the HIP Trust Fund may be used by the State pursuant to Section 7(F) below.

(C) For SFY 2021 and each subsequent SFY thereafter, the Parties agree to determine a formula whereby HAF funds will be annually deposited into the HIP Trust Fund to augment the balance of the HIP Trust Fund at an appropriate amount necessary to cover the annual operating expenses of HIP 2.0.

(D) The State will terminate the Waiver and provide written notice of such termination, along with a proposed phase-out plan to CMS, in the event of:

> (i) a reduction in an enhanced federal Medicaid match rate provided for in the current version of 42 U.S.C. §1396d(y)(1); or
>
> (ii) a change in federal law applicable to the HAF that reduces the amount of funds that federal law permits to be assessed by the HAF.

(E) During a phase-out of the Waiver, Hospital services will be reimbursed at Medicare rates.

(F) The HAF amounts deposited into the HIP Trust Fund pursuant to Subsection (B) of this Section 7 will only be used by the State to fund the State Share of the expenses upon the termination of HIP 2.0 incurred by the State (and for which CMS provides federal financial participation) during a phase-out of the Waiver.

(G) Upon the termination of HIP 2.0 for any reason, the State and IHA will agree upon a phase out plan for the Waiver. The total amount of funds required to phase out HIP 2.0 will be reduced by the amount of annual cigarette tax collections described in Section 4(B). The balance of the HIP Trust Fund, including contributions from the HAF described in Subsection (B), will be used to fund the remaining phase out expenses.

(H) Upon the completion of any phase out period required by the Waiver, the remaining HIP Trust Fund balance will be distributed to the State and Hospitals on a pro-rata basis based on the amounts on deposit in the HIP Trust Fund.

(I) The pro-rata portion of the remaining HAF contributions will be distributed to the Hospitals on a pro-rata basis based upon the hospital assessment fees paid by each Hospital for the SFY that ended immediately prior to the State's written notification referenced in Subsection (B) of this Section 7.

8. Reconciling Actual Costs and HAF Funding.

(A) Prior to the implementation of the HIP 2.0, the State and IHA will agree upon a process for accounting for actual costs incurred by the State with regard to the HIP 2.0, including, but not limited to:

(i) administrative costs;

(ii) for purposes of crediting against HAF funds, any penalties, recoupments, withhold amounts and similar sums, as well as gain sharing amounts (if any) the State receives from MCEs with regard to the HIP 2.0;

(iii) amounts paid to fund POWER accounts;

(iv) total payments by provider type and payments to specific Hospitals; and

(v) the amount of HAF funding used to fund such costs.

HAF funding will be based on enrollment or state costs incurred, and to the extent estimates are used there will be a transparent process created to reconcile with the actual experience with the HIP 2.0 in a manner consistent with current HAF program. This process will use the most accurate, timely, consistent, and verifiable data practically possible.

(B) Prior to the implementation of the HIP Expansion Program HIP 2.0, the State and IHA will agree upon a mechanism for ensuring that HAF funding for the HIP Expansion Program HIP 2.0 is clearly accounted for separately from funding for the existing Medicaid program or other State expenditures.

9. Managed Care.

(A) The State will contract with no fewer than two (2) MCEs for purposes of the HIP 2.0.

(B) The State will require that:

(i) MCEs pay health care providers at full Medicare Rates for services rendered to HIP 2.0 enrollees;

(ii) MCEs will maintain a minimum medical loss ratio of 87% such that at least 87% of the premiums they receive are paid to health care providers in reimbursement for the covered services such providers render to the MCE's respective HIP 2.0 enrollees; and

(iii) the MCEs do not implement any restricted network plan in the HIP 2.0 line of business, except for the existing purpose and scope of the Right Choices Program.

(C) In the event the State receives any penalties, recoupments, withhold amounts or similar amounts, as well as gain sharing amounts (if any) from MCEs with regard to the HIP 2.0, those amounts will be credited against the amount of HAF funds to be used for the HIP 2.0.

(D) IHA commits to maximizing the success of the consumer-driven aspects of the HIP 2.0, including identifying financial assistance programs for individuals to make POWER account contributions, educating patients on the benefits of the enhanced "HIP Plus" plan, developing strategies to facilitate co-payment collection, and other approaches developed in collaboration between Hospitals and the State. IHA agrees to annually report on their activities to the State.

10. IMD Exclusion. As part of the Waiver, the State will work with IHA to consider seeking authority for Hospitals that would otherwise be subject to the IMD exclusion to be reimbursed under the HIP 2.0 for services provided to HIP 2.0 enrollees between the ages of 22 and 64. In addition to the HIP 2.0, the State will work with IHA to consider seeking authority for Hospitals that would otherwise be subject to the IMD exclusion to be similarly reimbursed under other HAF funded Hospital services.

11. Role of the Hospital Assessment Fee Committee ("Committee").

(A) An affirmative vote of the Committee regarding the HAF formula to be used for the HIP 2.0 will be required before the HIP 2.0 program is implemented. The Committee's vote in regard to such HAF formula will occur after CMS grants the Waiver and the Waiver's terms and conditions are available for review by the Committee.

(B) In the event the State decides to extend the Waiver beyond its initial term, or replace the Waiver, or amend the Waiver in a manner that would materially affect Hospitals or the use of HAF funds, an affirmative vote of the Committee regarding the HAF formula will be required before any extension, renewal, replacement or amendment is implemented.

(C) The Committee shall be responsible for approving the annual HAF payments required in SFY 2021 and beyond, pursuant to Section 7(C).

12. Presumptive Eligibility Determinations by Hospitals. Effective no later than the date the HIP 2.0 is implemented, the State will permit Hospitals to engage in presumptive eligibility determinations to the fullest extent allowed under federal law, pursuant to 42 CFR §435.1110, or by CMS. As part of this effort, no restrictions will be placed on a Hospital's ability to engage in presumptive eligibility determinations (except for any limit expressly stated in federal law or by CMS) based on the Hospital's presumptive eligibility determinations

stemming from without at least one base year of data regarding the Hospital's presumptive eligibility determinations.

13. Other Possible Funding. As soon as practically possible, the State and IHA will undertake a review of whether or not other appropriate mechanisms are available to obtain additional financial support for the HIP 2.0.

14. Other Strategic Initiatives. The State and IHA will immediately begin work on the following:

(A) Exploring state budget-neutral opportunities for leveraging additional federal funds to promote new models of care, protect safety net providers in urban and rural areas (like Hospitals receiving DSH funds and Critical Access Hospitals).

(B) Addressing the design of the underlying HAF program, including possible amendments to the HAF and/ or HIP statutes, as needed to maintain or improve the equity, clarity and efficiency of the HAF program and mitigate any adverse impacts of using the HAF to fund HIP 2.0.

(C) Conducting a study regarding MCE practices of denying prior authorizations for Hospital care.

(D) The State agrees that per federal regulations the medically fragile population is entitled to State Plan services under the Waiver, which include Medicaid rehabilitation option services.

15. Notice/Inducement/ Agreement Not to Bring Action. As additional inducement to execute this Term Sheet, the Parties specifically acknowledge and agree that nothing in this Term Sheet gives either Party (whether in the Party's own name or through or on behalf of any other person or entity) or any non-party any right or claim against the IHA or against the State or any of its agencies, departments, employees, agents, officers, special state appointees, or contractors, in law, equity or otherwise claiming in any manner breach of contract or any other injury in reliance on the terms or any actions flowing from the terms of this Term Sheet. The State agrees it will post this Term Sheet on the OMB website. IHA agrees to notify its membership of the execution of this Term Sheet, and the terms therein.

IN WITNESS WHEREOF, the undersigned authorized individuals have executed this Term Sheet effective as of the date first written above.

OFFICE OF MANAGEMENT AND BUDGET for the STATE OF INDIANA

By: _____
Chris Atkins
Director, OMB

Date: 5/9/2014

INDIANA HOSPITAL ASSOCIATION, INC.

By: Douglas J Leonard
Douglas J. Leonard
President, IHA

Date: May 9, 2014