This Scope of Work is part of a Contract to provide statewide, risk-based managed care services to Medicaid beneficiaries enrolled in the State of Indiana's [MLTSS Program Name] program. The State is soliciting proposals from proven managed care entities (MCEs) to coordinate and provide member-driven, accessible, equitable and high-quality services to eligible Medicaid members for medical, behavioral, and long-term services and supports.

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

https://www.in.gov/medicaid/providers/provider-enrollment/become-a-provider/

Unless otherwise indicated, the requirements set forth in this Scope of Work apply to the Contractor's responsibilities under the [MLTSS Program Name] program. Definitions for terms cited throughout the Scope of Work are listed in Exhibit 6 unless otherwise specified.

1.0 Background

The Indiana Family and Social Services Administration (FSSA) manages the [MLTSS Program Name] program, which will serve approximately 106,000[1] Hoosiers. [MLTSS Program Name] is a statewide coordinated care program for Indiana's Medicaid enrollees who are 60 years of age and older and are eligible for Medicaid on the basis of age, blindness, or disability and have limited income and resources. All individuals who are 60 years of age or older in the target eligibility categories will be included unless they meet an exclusion, as specified in Exhibit 3. Enrollees include members who have a full Medicare benefit, those in a nursing facility, and those who are receiving long-term services and supports (LTSS) in a home or community-based setting.

The State is interested in contracting with MCEs that can perform the administrative functions of a typical insurer, can support members in strategies to address complex and chronic health conditions of the program population which includes many individuals with complex health conditions who are dually eligible for Medicare and Medicaid and/or receive LTSS, and can manage and integrate care along the continuum and settings of LTSS in Indiana.

[1] The enrollment figures provided in this Scope of Work are current figures only. Enrollment in the [MLTSS Program Name] program may increase or decrease in the future based upon federal policies, program priorities, available funding, etc.

In developing [MLTSS Program Name], FSSA seeks to achieve the following:

- Ensure more Hoosiers can choose to age at home and simplify access to Home and Community-Based Services (HCBS)
- Appropriately divert individuals from long-term nursing facility stays in accordance with a person-centered approach. Through high-quality care coordination, coordinated care across the delivery system and care continuum, including across Medicaid and Medicare for dually eligible members, and taking into account physical health, behavioral health, and social services
- Improve quality outcomes and consistency of care across the delivery system
- Provide person-centered and strengths-based care
- Ensure member choice, protections, and access
- Promote caregiver support and skill development
- Emphasize communication, training, and collaboration with network providers to ease administrative burden and help accomplish program goals
- Align incentives across the delivery system with improved health and quality of life outcomes
- Deliver cost-effective and accountable coverage
- Leverage data to make informed program and care decisions
- Understand, measure, and address health inequities in care and access
- Promote primary and preventive care
- Ensure the appropriate use of health care services
- Develop informed health care consumers by increasing health literacy and providing price and quality transparency of members and their informal caregivers
- Encourage quality, continuity, and appropriateness of medical care
- Develop innovative member and provider incentives
- Develop innovative utilization management techniques that incorporate member and provider education to facilitate the right care, at the right time, in the right location
- Engage in provider and member outreach regarding preventive care, wellness, and a holistic approach
- Expand the HCBS provider network, especially in rural areas.

The Contractor shall ensure that they follow all program requirements and guidance issued by the State including but not limited to the [MLTSS Program Name] MCE Policies and Procedures Manual as updated and amended periodically.

1.1 [MLTSS Program Name] Program Quality Goals

The Contractor shall be required to help lead the transformation of our Medicaid LTSS delivery system and to collaborate with the State and other [MLTSS Program Name] MCEs to achieve this mission. The contractor shall abide by the requirements further detailed in Section 7.0 Quality Improvement. The State has established three overarching Program Quality Goals for the [MLTSS Program Name] program:

FSSA [MLTSS Program Name] Program Quality Goals

Goal 1: Person-Centered Services and Supports – Develop service plans and deliver services in a manner that is person-centered, participant-driven, holistic, involves caregivers, and addresses SDOH.

Goal 2: Ensuring Smooth Transitions – Ensure continuity of care and seamless experiences for participants as they transition into the [MLTSS Program Name] program or among providers, settings, or coverage types.

Goal 3: Access to Services (Member Choice) – Assure timely access to appropriate services and supports to enable participants to live in their setting of choice and promote their well-being and quality of life.

The State wants to encourage ongoing investment and achieve lasting progress, therefore FSSA is committed to maintaining these goals for the first contract term and potential contract term extension years of the [MLTSS Program Name] program. For each goal, FSSA will establish focus areas, objectives, and performance targets which will evolve over time to reflect the maturation of the [MLTSS Program Name] program and MCEs. The Contractor will be expected to develop and accomplish annual workplans and make investments toward improved outcomes. Measures associated with certain objectives will also be identified as Pay for Outcomes measures, and the Contractors' performance on all quality goals will be shared publicly.

The [MLTSS Program Name] Program Quality Goals were developed with broad input from Indiana stakeholders – including members and member advocates – and are reflective of national best practices. These goals will also build a strong foundation for Indiana to effectively deliver and finance [MLTSS Program Name] program services, provide the best value to program members and Hoosier taxpayers, and produce improved program outcomes. **The State believes that achieving these goals will be a win-win for all involved parties**:

- For members, who will have increased choice and access to services as well as increased control over their services and supports;
- For providers, who will have clear, consistent messaging about program priorities and technical assistance and training to help them deliver services and supports in a manner that supports those priorities; and
- For MCEs, who will, through collaborative and aligned efforts, be able to more effectively support provider and member behavior change to achieve improved results.

MCE Investments in Quality

These overarching [MLTSS Program Name] Quality Goals reflect the State's highest priorities. As such, FSSA intends to award contracts to Contractors that offer innovative and evidence-based approaches in meeting these [MLTSS Program Name] Quality Goals. The State expects Contractors to align their resources toward achieving improvement in these goal areas. For example:

- Member and provider outreach and education efforts should support the goals
- In lieu of services and enhanced services offered by the MCE should be carefully selected to support these goals
- Member and provider incentives and Value-Based Purchasing arrangements should be designed to support these goals

The Contractor will be required to actively collaborate with the State and other [MLTSS Program Name] Contractors to design and implement initiatives and interventions that support these goals. This collaboration will be achieved through participation in formal committees and workgroups facilitated by the State, as well as by the execution of common strategies across MCEs. MCEs will be expected to share insights and best practices and to actively participate in and contribute to these quality improvement activities.

Focus Areas for Future Years

Member experience is an important component of our initial focus and will continue to be in future years, because member experiences serve as an important indicator of the quality of services provided by the MCEs. Examples of other focus areas (not listed in order of priority) to support the [MLTSS Program Name] Program Quality Goals, that were suggested by stakeholders for possible inclusion in future years:

Person-Centered Services and Supports
Possible Future Focus Areas: Coordination between Medicaid MCE and D-SNPs/other Medicare plans; Member goal attainment (LTSS and non-LTSS); Advance care planning and palliative care

Ensuring Smooth Transitions
Possible Future Focus Areas: Transitions among settings (Hospital, NF, HCBS); Transitions between MCEs/Medicare health plans; Members newly eligible for Medicare; Transitions from nursing facility to HCBS (when chosen by the member); Use of Event Notification System; Medicare-Medicaid Care Coordination; Completeness and accuracy of options counseling (Transitions into LTSS)

Access to Services (Member Choice)
Possible Future Focus Areas: Direct service worker workforce initiatives; Home Health nursing workforce initiatives; Timely member access to HCBS; Availability of Informal Caregiver Supports; Connections with social determinants of health (SDOH) and closed-loop referrals; HCBS Utilization; Potentially Preventable Events and/or Adult Core Measures (as an indicator of access to preventive care); Primary care visits; Community inclusion; Healthy Days at Home; Loneliness

Initial Objectives for [MLTSS Program Name] Quality Goals
To actively support the [MLTSS Program Name] Program Quality Goals, we have developed measurable objectives and performance targets that each of the MCEs will be required to meet. Certain objectives have been designated as Pay for Outcomes measures. For those measures, higher incentive payments will be made to MCEs that reach targets above the benchmarks identified in the Pay for Outcomes in Exhibit 2.

These initial focus areas and objectives were designed to focus on building infrastructure that will enable the State to more effectively manage and deliver care and services in future years. Thus, the initial objectives largely rely on structural and process measures.

2.0 Administrative Requirements

2.1 Eligibility Requirements

The State has sole authority for determining whether individuals meet the eligibility criteria of the [MLTSS Program Name] program. The FSSA Division of Family Resources (DFR) makes eligibility determinations based on federal and state policy as interpreted by OMPP. Nursing Facility Level of care is determined based on state law and administrative rule.

- *Age and Target Group*

  In order to be eligible to enroll in an MCE, an individual must be in the age and target groups served by the MCE as specified below.

- *Medicaid Eligibility*

  The population for this program is individuals 60 and older who are eligible for Medicaid on the ~~basis~~ of age, blindness, or disability and have limited income and resources. All members aged 60 and older in the target eligibility categories will be included unless the individual meets an exclusion. This includes members who have a full Medicare benefit and those in a nursing facility.

Included	Individuals aged 60 years of age or over who are enrolled in Medicaid based on eligibility as:

	Aged (MA A) Blind (MA B) Disabled (MA D) SSI recipients (MASI) MED Works (MADW, MADI) Full-Benefit Dually-Eligible individuals (QMB-also, SLMB-also, and FBDE) Including those who are: -Eligible for the A&D waiver -In a nursing facility
Excluded	-Partial Benefit Dually-Eligible individuals (QMB-only, SLMB-only, QI, QDWI) -Anyone under 60 years of age on the A&D waiver -DDRS Waiver Recipients -PACE Members -Room and Board RCAP members -ESRD 1115 members -Breast and Cervical Cancer Eligible members (MA 12) -TBI Waiver Recipients -TBI Out of State Placements -ICF/IDD residents -Emergency Services Only Members -Family Planning Only Members -HIP members with MAGI eligibility -HHW members with MAGI eligibility -Registered members of a federally-recognized Tribe who are eligible for HIP but have opted out into FFS coverage (MANA)

- *Functional Eligibility*
  Functional eligibility is determined using the InterRAI assessment.
    - In order to be functionally eligible for Long-Term Services and Supports an otherwise eligible individual must have a nursing facility level of care as determined by the InterRAI assessment and meet the requirements under Indiana Code 12-10-11.5-4. This level of care will be completed by an Enrollment Contractor selected by FSSA. Managed Care Entities will not determine the member's level of care. For nursing facility admittance only, if the individual is reasonably expected to no longer meet nursing facility level of care within a time period of 30, 60, 90, or 120 days the nursing facility level of care must be reassessed in that respective time period. Additionally, for anyone receiving LTSS, the nursing facility level of care must be reassessed at least annually. The benefit package available to members is identified in Exhibit 3 Covered Benefits.
- *Residency*
  To be eligible for [MLTSS program name], an otherwise eligible individual must be a resident, as determined by DFR using rules found in the Indiana Health Coverage Policy & Program Manual (https://www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-eligibility-policy-manual/).

- *MCE Assignment*
  For individuals who come into the program with no current Medicaid coverage, MCE

assignment will be effective on the date of eligibility approval. Medicaid coverage may be effective up to three (3) months retroactively from their application date. Retroactive coverage will be in the fee for service (FFS) program, the managed care assignment will not be retroactive.

Individuals transitioning from an existing Medicaid Managed Care program or FFS, MCE assignment will be effective the first day of the month following the notice of change in eligibility.

Plan selection can be made on the IHCP application or by calling the enrollment broker within sixty (60) days of coverage start. If a member does not select a plan there will be an assignment process in place directed by the State. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the residential provider of the member (if applicable).

Individuals will have the chance to change a health plan:

1) within sixty (60) days of starting coverage,
2) at any time their Medicare and Medicaid plans become unaligned (e.g. member disenrolls from one MA plan to another during quarterly Special Enrollment Period (SEP),
3) once per calendar year for any reason,
4) at any time using the just cause process; and
5) Additionally, during a plan selection period which will be aligned with the Medicare open enrollment window (mid-October to mid-December) to be effective the following calendar year.

- *Medicare Election*
    - To enroll, a prospective member who is eligible for Medicare must:
        - Enroll in and remain enrolled in all parts of Medicare for which the prospective member is eligible (Medicare Part A, Part B, and/or Part D); or
        - Obtain all Medicare Part A, Part B, and Part D benefits, if eligible, from the MCE's Special Needs Plan.
    - If a member becomes Medicare-eligible after enrollment, the member must enroll in all parts of Medicare for which the member is eligible.

2.1.1 Eligibility Determination Process

1. *Eligibility Determination Prior to Initial Enrollment*
    a. The Contractor will assure the Contractor's separation from the FSSA initial eligibility determination and enrollment counseling functions. The separation shall meet criteria established by the State in accordance with applicable federal and state guidelines.

    b. Contractors may market directly to members or potential members only in accordance with a marketing plan that has been approved by the State and may use only marketing materials that have been approved by the State.
2. *Functional Eligibility Re-determination*
Once enrolled, the Contractor is responsible to assure that all members have a current and accurate level of care as determined by the InterRAI, in accordance with Section 2.1.2 Long-Term Care Functional Screen. This includes at minimum an annual re-determination of level of care. It may also include a post-enrollment re-determination shortly after enrollment or a re-determination necessitated by a change in the member's condition. The Contractor shall not complete the level of care determination, but work with the FSSA

Enrollment Contractor and member to have the level of care determined annually and when a change in the member's condition occurs.

3. *Supporting Members to Maintain Medicaid Eligibility*
   The Contractor is responsible for supporting members with maintaining Medicaid eligibility. This includes but is not limited to:

   a. Reminding members of the required annual Medicaid recertification procedure and coordinating member transportation to any needed DFR appointments;

   b. Educate members on any applicable Medicaid income and asset limits and as appropriate and needed, supporting members to meet verification requirements;

   c. Educate members on any deductible, cost share, patient or waiver liability obligation, or transfer penalty period they may need to meet to maintain Medicaid eligibility;

   d. If appropriate and needed, supporting members to obtain a representative payee or legal decision maker; and

   e. Referring and connecting members as needed to other available resources in the community that may assist members in obtaining or maintaining eligibility such as Elder and Disability Benefits Specialists and advocacy organizations.

4. *Providing Information that May Affect Eligibility*
   Members have a responsibility to report certain changes in circumstances that may affect Medicaid eligibility to DFR within ten (10) calendar days of the change. The Contractor is expected to be knowledgeable of eligibility criteria and educate members in reporting known changes to the DFR.

   Notwithstanding the member's reporting obligations, if the Contractor has information about a change in member circumstances that may affect Medicaid eligibility, the Contractor is to provide that information to DFR as soon as possible but in no event more than ten (10) calendar days from the date of discovery (see Section 5.2 Member Enrollment and Contractor Selection).

   Members who receive SSI benefits are required to report certain changes to the Social Security Administration rather than DFR. The Contractor shall support members in meeting these reporting requirements since loss of SSI has a direct impact on Medicaid eligibility.

   Reportable information includes:

   - An initial LOC determination that qualifies an individual for additional LTSS services or a change in a member's LOC;
   - The member has died;
   - The member has been incarcerated;
   - The member has a verified move either within the state or to another state;
   - Any known changes in the member's income or assets;
   - Changes in the member's marital status.

5. *Medicare Coverage Elections*
   The Contractor is responsible for having the requisite staff knowledge and resources to support members in effectively understanding any Medicare coverage choices, including traditional Medicare, Medicare Advantage (non-special needs plans), and Special Needs Plans (SNPs) as well as all relevant Medicare enrollment periods, including the Open Enrollment Period (OEP) and Special Enrollment Periods (SEPs) in order to avoid unintended misalignment or even potential disenrollment from the program.

6. *Waiver or Patient Liability*

The Contractor is responsible for the ongoing monitoring of the waiver or patient liability amounts of its members. The Contractor is to receive and monitor medical claim amounts and apply allowable costs against the liability to ensure member responsibility is met; and to cover allowable costs after the liability is met.

Members may be required to pay a monthly waiver or patient liability in order to be eligible for [MLTSS Program Name]. Liability is the term applied to the monetary amount that IHCP members in long-term care (HCBS or nursing facility) must contribute toward their monthly care.

a. Waiver liability is similar to a deductible and applies to members who live in the community (such as their own home, an adult family home, a community-based residential facility or a residential care apartment complex). Waiver members will be allowed to keep a monthly personal needs allowance (PNA) equivalent to the current year's special income limit amount (SIL, as specified by 405 IAC 2-1.1-1(g)). No claims are reimbursable until the waiver liability has been met.

    - For waiver members with a waiver liability assigned, the Contractor must provide a system to track Medicaid-allowable expenses; when such expenses exceed the waiver liability amount, they should be paid by the Contractor. The provider should be able to see the waiver liability obligation and balance in the portal or when checking eligibility.
    - Monthly waiver liability summary notices must be sent to the member and any authorized representative. The notice must detail the services and amounts applied to the waiver liability. With the exception of pharmacy claims, the member is not required to pay the provider until the expense has been included in the waiver liability summary notice.
    - It is the member's responsibility to supply verification of medical expenses not allowed for payment by Medicare or Medicaid to the DFR for possible deduction in the initial liability assignment calculation.
    - The Contractor must also establish systems and procedures to properly apply Medicare Crossover Payments to waiver liability according to Indiana Health Coverage Programs guidance regarding third-party liability. For members with waiver liability who have not met their liability for the month, Medicare crossover claims credit the waiver liability with the combined sum of the amounts shown as the coinsurance or copayment, blood deductible, and deductible.
    - The billed amount of a crossover claim cannot be used to credit waiver liability.
    - The coinsurance or copayment and deductible amounts for Medicare Part A claims are prorated, based on the number of days billed.
    - Medicare Part B claims spanning more than 1 month are credited to the month of the first date of service.
    - Coinsurance or copayment and deductible amounts on crossover claims for members who have only Qualified Medicare Beneficiary coverage (QMB-Only) do not credit waiver liability
    - Patient liability applies to members who reside in a nursing home or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) for 30 or more consecutive days or are likely to reside there for 30 or more consecutive days. The personal needs allowance for this group is $52 monthly plus, if applicable, veterans' pensions; as specified in IC 12-15-7-2. State Plan services can be paid without regard to whether the patient liability has been met.

- Patient liability amounts are to be deducted from the total reimbursement of monthly claims to the facility. Providers are not to indicate or exclude the liability when submitting claims. The patient liability amount should be visible in the provider portal or when the provider checks eligibility.
- When a member transfers between facilities during a billing period, the member liability is deducted from the first claim received and processed by the MCE. Therefore, the facilities involved in the transfer must coordinate any liability deductions.
    - DFR is responsible for determining the amount of a member's waiver or patient liability. Waiver liability is imposed on members in accordance with 42 C.F.R. § 435.726. Patient liability is imposed in accordance with 42 C.F.R. § 435.725. Member information, including waiver/patient reflected in the MMIS, is updated daily from the information relayed by the eligibility and enrollment system and will be communicated to the appropriate MCE. Liability amounts will not change in the middle of a month.
    - The Contractor should be knowledgeable and able to answer questions on liabilities and provide current information to members who contact them with questions.

7. *Transfer of Property Penalties*
   DFR will determine if an applicant or member for LTSS Medicaid has inappropriately transferred assets without adequate consideration in order to qualify for Medicaid, as specified in 405 IAC 2-3-1.1. A monthly "facility rate" will be set by the state annually, and the transfer penalty period will be equal to the amount of the disallowed transfer divided by the facility rate to arrive at the number of months of penalty. The dates of any penalty period will be communicated to the Contractor from the MMIS system. During a penalty period, LTSS services above the member's State Plan benefits are not payable by Medicaid. Provider portal and eligibility-checking systems must indicate to providers the start and end dates of member ineligibility due to transfer of property penalty. Transfer of property penalties will always start on the first day of a month but can end on any day of a month.
    a. The Contractor should be knowledgeable and able to answer questions on transfer of property penalties and provide information to members who contact them with questions.

2.1.2 Long-Term Care Functional Screen

- *Functional Screen Tool and Database*

  The tool used for determining level of care is the InterRAI-HC assessment.

- *Notification of Changes in Functional Eligibility Criteria*

  The State will notify the Contractor of any changes in administrative code requirements related to functional eligibility, including, but not limited to, code changes that result in changes to determining functional eligibility for the programs.

2.2 State Licensure

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

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

The Contractor and all subcontractors shall use clinicians licensed by Indiana and follow all requirements contained within the Contract (e.g., PA/UM criteria; claims processing; encounter data submission; etc.), regardless of geographic location.

2.3 National Committee for Quality Assurance (NCQA) Accreditation

As required by IC 12-15-12-21, the Contractor shall be an accredited Health Plan by the National Committee for Quality Assurance (NCQA) with the LTSS Distinction. When accreditation standards conflict with the standards set forth in the Contract, the Contract prevails, unless the accreditation standard is more stringent.

If the Contractor is accredited as of the start date of the Agreement, the Contractor shall maintain accreditation throughout the term of this agreement. If the Contractor is not accredited as of the start date of this agreement, the Contractor shall obtain their Health Plan accreditation and the LTSS Distinction for Health Plans no later than the end of the second full calendar year of operation and shall maintain accreditation for the term of this Agreement.

The Contractor must submit to FSSA the final Accreditation Report for each accreditation cycle within ten (10) days of receipt of the report. The Contractor must submit to FSSA updates of accreditation status, based on annual HEDIS scores, within ten (10) days of receipt.

As required by 42 C.F.R. § 438.332(c), FSSA shall publish on its website the accreditation status of each Contractor.

2.4 Administrative and Organizational Structure

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

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

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

- Administrative and fiscal management
- Member services
- Provider enrollment and services
- Case Management
- Marketing
- Network development and management
- Quality management and improvement
- Utilization management

- Clinical assessment, prevention and wellness program(s), care coordination, complex case management, and service coordination,
- Special investigations and waste, fraud, and abuse detection
- Behavioral and physical health
- Information systems
- Performance data reporting and encounter claims submission
- Claims payments
- Grievances and appeals
- Medicare and Medicaid coordination

2.4.1 Staffing

The Contractor shall ensure qualified staff in each major operational area has appropriate skills, knowledge, and experience with the unique aspects of geriatrics, LTSS populations and services, Home and Community Based Services (HCBS) coordination, as well as the coordination of Medicare and Medicaid. Prior LTSS experience or experience serving the program population across staff is preferred. Staff will be culturally competent. The Contractor shall maintain a high level of Contract performance and data reporting capabilities regardless of staff vacancies or turnover. The Contractor shall have an effective method to address and minimize staff turnover (e.g., cross training, use of temporary staff or consultants, etc.) as well as processes to solicit staff feedback to improve the work environment. These processes will be verified during the readiness review.

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

2.4.2 Key Staff

The Contractor shall employ the key staff members listed below. The State requires the Contractor to have key staff members dedicated full-time to the Contractor's Indiana Medicaid product lines. In some instances, key staff must be dedicated to [MLTSS Program Name]. The Contractor must employ qualified staff to achieve compliance with contractual requirements and performance metrics.

The Contractor shall set up and maintain a business office or work site within ten (10) miles of the mile square of downtown Indianapolis, Indiana, from which, at a minimum, key staff members may easily access to conduct duties and responsibilities, meet with the State, and perform a major portion of the Contractor's operations. The Contractor shall be responsible for all costs related to securing and maintaining the facility for interim start-up support and the subsequent operational facility.

The Contractor shall deliver a final staffing plan on a schedule determined by the State as a part of readiness in advance of the contract effective date. FSSA reserves the right to approve or disapprove all initial and replacement key staff prior to their assignment to [MLTSS Program Name]. FSSA shall have the right to require that the Contractor remove any individual (whether or not key staff) from assignment to the program.

The Contractor shall ensure the location of any staff or operational functions outside of the State of Indiana does not compromise the delivery of integrated services and the seamless experience for members and providers. The Contractor shall be responsible for ensuring all staff functions

conducted outside of the State of Indiana are readily reportable to FSSA at all times to ensure such locations do not hinder the State's ability to monitor the Contractor's performance and compliance with Contract requirements. Indiana-based staff shall maintain a full understanding of the operations conducted outside of the State of Indiana and must be prepared to discuss these operations with FSSA upon request, including during unannounced FSSA site visits.

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

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

FSSA reserves the right to interview any prospective candidate and/or approve or deny the individuals filling the key staff positions set forth below. FSSA also reserves the right to require a change in key staff as part of a corrective action plan should performance concerns be identified.

The key staff positions required under the Contract include:

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

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

Compliance Officer – The Contractor shall employ a Compliance Officer who is accountable to the Contractor's executive leadership and dedicated full-time to the Contractor's Indiana Medicaid product lines. This individual will be the primary liaison with the State (or its designees) to facilitate communications between FSSA, the State's contractors, and the Contractor's executive leadership and staff. This individual shall maintain current knowledge of federal and state legislation, legislative initiatives, and regulations that may impact the [MLTSS Program Name] program. It is the responsibility of the Compliance Officer to coordinate reporting to the State as defined in Section 10.0 and to review the timeliness, accuracy, and completeness of reports and data submissions to the State. The Compliance Officer, in close coordination with other key staff, has primary responsibility for ensuring all Contractor functions are compliant with the terms of the Contract.

Chief Information Officer (CIO) or Information Technology (IT) Director – The Contractor shall employ a CIO or IT Director who is dedicated full-time to the Contractor's Indiana Medicaid product lines. This individual will oversee the Contractor's [MLTSS Program Name] Information Technology (IT) systems and serve as a liaison between the Contractor and the State fiscal agent or other FSSA contractors regarding encounter claims submissions, capitation payment, member eligibility), enrollment, and other data transmission interface and management issues. The CIO or IT Director, in close coordination with other key staff, is responsible for ensuring all program data transactions are compliant with the terms of the Contract. The CIO or IT Director is responsible for attendance at all Technical Meetings called by the State. If the CIO or IT Director is unable to

attend a Technical Meeting, the CIO or IT Director shall designate a representative to take their place. This representative shall report back to the CIO or IT Director on the Technical Meeting's agenda and action items. For more information on the IT program requirements, see Section 9.0.

Medical Director – The Contractor shall employ the services of a Medical Director who is an Indiana-licensed Indiana Health Care Provider (IHCP) provider board certified in geriatrics, family medicine, or internal medicine. If the Medical Director is not board-certified in geriatrics, family medicine, or internal medicine they shall be supported by an Indiana licensed clinical team with experience in geriatrics, palliative care, behavioral health, and adult medicine. The Medical Director shall be dedicated full-time to the Contractor's Indiana Medicaid product lines. The Medical Director shall oversee the development and implementation of the Contractor's prevention and wellness programs(s), case management, and care management programs; oversee the development of the Contractor's clinical practice guidelines; review any potential quality of care problems; oversee the Contractor's clinical management program and programs that address special needs populations; oversee health screenings; serve as the Contractor's medical professional interface with the Contractor's primary medical providers (PMPs) and specialty providers; direct the Quality Management and Utilization Management programs, including, but not limited to, monitoring, corrective actions, and other quality management, utilization management or program integrity activities. The Medical Director, in close coordination with other key staff, is responsible for ensuring that the medical management and quality management components of the Contractor's operations are compliant with the terms of the Contract. The Medical Director shall work closely with the Pharmacy Director to ensure compliance with pharmacy-related responsibilities set forth in Section 3.3. The Medical Director shall attend all FSSA quality meetings, including the Quality Strategy Committee meetings and Subcommittee meetings. If the Medical Director is unable to attend an OMPP quality meeting, the Medical Director shall designate a representative to take their place. This representative must report back to the Medical Director on the meeting's agenda and action items. The Medical Director shall be responsible for knowing and taking appropriate action on all agenda and action items from all OMPP quality meetings.

Staff Geriatrician or Physician with Ten (10) Years of Clinical Practice with Older Adults- The Contractor must employ the services of an Indiana-licensed Geriatrician or physician with ten (10) years of clinical practice with older adults (60 years of age and older) who is dedicated full time to the [MLTSS Program Name] program that assists the Utilization Management, Care Management, and Quality departments' staff to understand the complex needs and care of older adults.

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

services operations are compliant with the terms of the Contract. For more information regarding the member services program requirements, see Section 5.0. The Member Services Manager shall have prior experience in LTSS or with the program population.

Provider Services Manager – The Contractor shall employ a Provider Services Manager who is dedicated full-time to the [MLTSS Program Name] program. The Provider Services Manager shall, at a minimum, be responsible for the provider services helpline performance, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials, and developing outreach programs. The Provider Services Manager oversees the process of providing information to the State fiscal agent regarding the Contractor's provider network. The Provider Services Manager, in close coordination with other key staff, is responsible for ensuring that all of the Contractor's provider services operations are compliant with the terms of the Contract. The individual should be knowledgeable in facility licensure and IHCP enrollment. For more information regarding the provider services program requirements, see Section 6.0. Prior experience as an LTSS provider preferred.

Special Investigation Unit Manager – The Contractor shall employ a Special Investigation Unit (SIU) Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The SIU Manager shall be located in Indiana. The SIU Manager is responsible for directing the activities of Special Investigation Unit staff, attending meetings with FSSA and reducing or eliminating wasteful, fraudulent, or abusive healthcare billings and services. It is the responsibility of the SIU Manager to coordinate the timeliness, accuracy, and completeness of all suspected or confirmed instances of waste, fraud, and abuse referrals to the OMPP PI Section. The SIU Manager shall report to the Compliance Officer and meet with the OMPP Program Integrity (OMPP PI) Section at a minimum of quarterly or more frequently as directed by the OMPP PI Section. The SIU Manager shall be a subject matter expert in Medicaid program integrity and hold qualifications similar to those of state program integrity section managers.

Long-Term Services and Supports Program Manager – The Contractor shall employ an LTSS Program Manager who is dedicated full-time to the [MLTSS Program Name] Program. The LTSS Program Manager shall, at a minimum, oversee and be responsible for all the [MLTSS Program Name] Program operations and requirements. The LTSS Program Manager shall work with the Contractor's Key Staff members and with State staff as necessary, to ensure the program meets the State's goals and the Contractor's operations are aligned across all functional areas. The LTSS Program Manager will provide input, as requested by the State, at State-level meetings. The LTSS Program Manager shall have at least five (5) years of prior experience in administering managed long-term care programs and experience administering LTSS with the program population. On a case-by-case basis, equivalent experience in administering long-term services and supports programs, including HCBS, may be substituted, and is subject to the prior approval of the State.

Quality Management Manager – The Contractor shall employ a Quality Management Manager who is dedicated full-time to the [MLTSS Program Name] program. The Quality Management Manager shall, at a minimum, be responsible for directing the activities of the Contractor's quality management staff in monitoring and auditing the Contractor's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Quality Management Manager shall assist the Contractor's Compliance Officer in overseeing the activities of the Contractor's operations to meet the State's goal of providing health care services that improve the health status and health outcomes of [MLTSS Program Name] members. For more information regarding the quality management requirements, see Section 7.0.

Utilization Management Manager – The Contractor shall employ a Utilization Management Manager who is dedicated full-time to the [MLTSS Program Name] program. The Utilization Management Manager shall be responsible for directing the activities of the utilization

management staff. With direct supervision by the Medical Director and a staff geriatrician, the Utilization Management Manager shall direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, appropriate utilization of health care services, continuity of care, and other clinical and medical management programs. The Utilization Management Manager shall work with the Special Investigation Unit (SIU) Manager to assure that service billing and utilization issues are documented and reported to the SIU, and matters requiring SIU review or investigation shall be timely submitted within five (5) business days to enable recovery of overpayments or other appropriate action. For more information regarding the utilization management requirements, see Section 7.8. The Utilization Management Manager shall have prior experience in LTSS or with the program population.

/Care Coordination Manager – The Contractor must employ a full-time Care Management Manager dedicated to the [MLTSS Program Name] program. This Manager must oversee the prevention and wellness programs(s), care management, complex case management, and Right Choices Program (RCP) functions as outlined in Section 4.2. The Care Management Manager must, at a minimum, be a registered nurse or a Master's level social worker with at least five years of experience in providing care coordination to older adults. This individual will work directly under the Contractor's Medical Director to develop, expand and maintain the care coordination program. The individual will be responsible for overseeing care coordination teams, care plan development, and care plan implementation. The Care Management Manager will be responsible for directing the activities of the care coordinators. These responsibilities extend to physical and behavioral health care services. This individual will work with the Medical Director, Geriatrician, Service Coordination Administrator, Provider and Member Services Managers, and with State staff as necessary, to communicate to providers and members. The Care Management Manager will provide input, as requested by the State, at State-level meetings. The Care Management/Care Coordination Manager shall have prior experience in LTSS or working with the program population and experience facilitating and working in coordination with an Interdisciplinary Team.

Service Coordination Administrator – The Contractor shall employ a Service Coordination Administrator dedicated to the [MLTSS program name] program who is an Indiana licensed registered nurse in good standing with a minimum of three years of management experience or a Master's level social worker with a minimum of three years of management experience. The individual must have experience with long term services and supports and home and community-based service coordination as it relates to implementing practices to improve social determinants of health as well as knowledge about Indiana community resources, and prior experience with the program population and informal caregivers. The Service Coordinator Administrator/Manager shall work in partnership with the Care Management/Care Coordination Manager and supervise the service coordinators.

Behavioral Health Manager – The Contractor shall employ a Behavioral Health Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. The Behavioral Health Manager is responsible for ensuring that the Contractor's behavioral health operations, which include the operations of any behavioral health subcontractors, are compliant with the terms of the Contract. The Behavioral Health Manager shall coordinate with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach, and education, member services, contract compliance, care management, service coordination, and reporting. The Behavioral Health Manager shall fully participate in all quality management and improvement activities, including participating in Quality Strategy Committee meetings and in the Mental Health Quality Assurance Committee. The Behavioral Health Manager shall work closely with the Contractor's network development and provider relations staff to develop and maintain the behavioral health network and ensure that it is fully integrated with the physical health provider network. The Behavioral Health Manager shall collaborate with key staff to ensure the coordination of physical and behavioral health care as set forth in Section 3.6 and coordination with Medicaid Rehabilitation Option (MRO) and 1915(i) services as set forth in Sections 3.20.1 and 3.20.2. The Behavioral Health Manager shall work

closely with the utilization management staff to monitor behavioral health utilization, especially to identify and address potential behavioral health under- or over-utilization. The Behavioral Health Manager or designee shall be the primary liaison with behavioral health community resources, including Community Mental Health Centers (CMHCs), and be responsible for all reporting related to the Contractor's provision of behavioral health services. The Behavioral Health Manager shall be knowledgeable about the care of older adults and their behavioral health needs including comorbidities such as dementia, intellectual and developmental disabilities, and serious mental illness diagnosis.

If the Contractor subcontracts with a behavioral health organization (BHO) to provide behavioral health services, the Behavioral Health Manager shall continue to work closely with the Contractor's other managers to provide monitoring and oversight of the BHO and to ensure the BHO's compliance with the Contract (See Section 2.9 regarding requirements for FSSA's approval of subcontractors.).

Dental Manager – The Contractor must employ an Indiana Dentist as a Dental Manager who is dedicated full-time to the Contractor's Indiana Medicaid product lines. This individual, in coordination with the Medical Director, is responsible for ensuring the dental benefit operated by the Contractor or subcontractor is compliant with standards of dental care and consistent with this Contract. The Dental Manager establishes and coordinates with implementation of the Contractor's oral health strategy to ensure comprehensive, whole person health.

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

Pharmacy Director – The Contractor shall employ a Pharmacy Director who is an Indiana licensed pharmacist dedicated full-time to the Contractor's Indiana Medicaid product lines. The Pharmacy Director shall oversee all pharmacy benefits under this Contract as outlined in Section 3.3 and have knowledge and experience in geriatric pharmacy as it relates to HCBS participants. This individual shall represent the Contractor at all meetings of the State's Drug Utilization Review (DUR) Board meetings and the Mental Health Quality Assurance Advisory Committee (MHQAC). If the Contractor subcontracts with a Pharmacy Benefits Manager (PBM) for its [MLTSS Program Name] pharmaceutical services, the Pharmacy Director shall be responsible for oversight and Contract compliance of the PBM, including pharmacy audits, as well as any other audits or responses.

Transition Coordinator – The Contractor shall employ a Transition Coordinator located in Indiana dedicated full-time to the [MLTSS Program Name] program who is a health care professional or who possesses the appropriate education and experience and is supported by a health care professional. The Transition Coordinator will oversee and coordinate the initial and ongoing member transitions in and out of the various Indiana Medicaid programs, the Contractor's enrollment, and among care settings. The Transition Coordinator shall work closely with the transition coordination staff, providers and the State to obtain, utilize and share member transfer information to safeguard successful, timely, and orderly transitions. The Transition Coordinator shall have prior experience in LTSS or with the program population.

Member Advocate/Non-Discrimination Coordinator – The Contractor must employ a Member Advocate/Non-Discrimination Coordinator dedicated full-time to the [MLTSS Program Name] program who is responsible for the representation of members' interests including input in policy development, planning, and decision-making. Member Advocate/Non-Discrimination Coordinator shall have knowledge and experience about HCBS consumer concerns related to HCBS providers and services and have strong conflict resolution and problem-solving skillset. The Member Advocate shall be responsible for the development and oversight of the Member and Informal Caregiver Advisory Committee. This individual shall also be responsible for the Contractor's compliance with federal and state civil rights laws, regulations, rules, and policies, including but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) and the Age Discrimination Act. The Member Advocate/ Non-Discrimination Coordinator shall have prior experience in LTSS or with the program population.

Grievance and Appeals Manager – The Contractor shall employ a Grievance and Appeals Manager dedicated to the Contractor's Indiana Medicaid product lines and is responsible for managing the Contractor's grievance and appeals process. This individual shall be the primary staff member responsible for ensuring compliance with processing timelines and policy and procedure adherence as outlined in Section 5.14 and will collaborate with the Member Services Manager to ensure root cause analyses are completed to address member concerns The Grievance and Appeals Manager shall ensure the Contractor has appropriate representation and/or provides adequate documentation in the event that a member appeals to the State.

Claims Manager – The Contractor shall employ a Claims Manager dedicated full-time to the Contractor's Indiana Medicaid product lines and responsible for ensuring prompt and accurate provider claims processing in accordance with the terms of the Contract. This individual shall work in collaboration with the CIO or IT Director to ensure the timely and accurate submission of encounter data as delineated in Section 9.8. The Claims Manager (or Utilization Management Manager, as applicable) shall work with the Special Investigation Unit (SIU) Manager to assure that service billing and utilization issues are documented and reported to the SIU, and matters requiring SIU review or investigation shall be timely submitted within (5) business days to enable recovery of overpayment or other appropriate action.

Nutritionist – The Contractor must employ or contract a full-time nutritionist dedicated to the Contractor's Indiana Medicaid lines of business. The Nutritionist must be a dietician licensed in Indiana. This individual shall serve as a resource for the Contractor's care management and service coordination teams and have duties that include reviewing care plans for members who are on medically prescribed diets, receiving gastric tube feeding, or experiencing weight loss. The Nutritionist would identify members who are at nutritional risk in accordance with medical standards and provide intervention recommendations to the Contractor's care teams. The Nutritionist shall partner with the Dental Manager and shall have prior experience in LTSS or with the program population and experience with gastric tube feeding, weight loss, and prescribed diets.

Equity Officer – The Contractor must employ a full-time Equity Officer dedicated to the Contractor's Indiana Medicaid product lines. The Equity Officer will provide leadership and management to define, implement, and evaluate strategies to achieve equitable access and reduce disparities in clinical care and quality outcomes. This strategy must include tracking, assessing, and improving disparities in care, and supporting the diverse cultural, language, disability, economic, education, and health status needs of those served by the Contractor.

Housing Coordinator – The Contractor must employ a full-time Housing Coordinator dedicated to the [MLTSS Program Name] program who can work with care/case managers to assist members and work with statewide and local housing entities to find appropriate housing services and supports for members in [MLTSS Program Name]. This person shall have experience in supporting older adults and/or persons with disabilities to secure accessible, affordable housing

through Federal and local programs including the Indiana Housing and Community Development Authority programs, HUD subsidized housing and voucher programs, public housing authorities, the Homeless Management Information System (HMIS), and USDA's Rural Development Single Family and Multi-Family programs. The Housing Coordinator shall be responsible for working with the aforementioned housing agencies to help develop and access affordable housing services for members receiving LTSS, educating and assisting Care/Service Coordinators and network providers regarding affordable housing services.

Workforce Development Administrator – The Contractor must employ a full-time Workforce Development Administrator dedicated to the [MLTSS Program Name] program who is responsible for coordinating and overseeing workforce development (WFD) activities. The Workforce Development Administrator shall have a professional background, authorities, and ongoing training and development needed to lead workforce development. The Workforce Development Administrator shall have experience with workforce recruitment, selection, training, and development, deployment and retention, training in WFD functions such as workforce forecasting, assessment, planning, and the provision of technical assistance in WFD matters specific to LTSS workforce needs. The Workforce Development Administrator shall work together with the Provider Services and Quality Management departments to ensure the provider network has 1) sufficient qualified workforce capacity to provide services, 2) required level of workforce that is interpersonally, clinically, culturally, and technically competent in the skills needed to provide services, and 3) connected workplaces with an internal capacity for developing their workforce and/or are connected to external workforce development resources.

Non-Emergent Medical Transportation (NEMT) Manager – The Contractor must employ a full-time Non-Emergent Medical Transportation (NEMT) Manager dedicated to the [MLTSS program name] program who is responsible for guaranteeing the Contractor has an effective transportation strategy and for overseeing the Contractor's NEMT broker, if applicable. The NEMT Manager shall proactively work to resolve potential transportation disruptions, implement creative solutions to ensure member transport, promote communication between the State and the Contractor on NEMT issues, conduct audits and reviews of the Contractor's NEMT broker, and respond to complaints and concerns from medical providers, facilities, drivers, and members alike. Building and maintaining an adequate transportation network to serve all member needs is paramount. This position will have significant interaction with other health care providers such as nursing facilities, assisted living facilities, dialysis centers, hospitals, and emergency medical services and will be required to work with providers to resolve issues ensuring member access to care and services.

2.4.3 Other Required Staff Positions

In addition to the required key staff described in Section 2.4.2, the Contractor shall employ those additional staff necessary to ensure the Contractor's compliance with the State's performance requirements. Required staff includes but are not limited to:

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

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

Quality Management Staff dedicated to performing quality management and improvement activities, participating in the Contractor's internal Quality Management and Improvement Committee. The Contractor shall include at least one (1) designated professional with expertise in the assessment and delivery of LTSS who will be substantially involved in the quality program.

Utilization and Medical Management Staff a minimum of seventy (70) percent of whom shall be located in Indiana. The utilization and medical management staff are dedicated to performing utilization management and review activities. These individuals who review authorizations for the [MLTSS Program Name] program must have experience in long term services and supports or the care of older adults.

Case Management Supervisor(s) who is an Indiana licensed registered nurse in good standing or a social worker with a minimum of three years of case management experience; or who has a degree in psychology, special education, or counseling, with a minimum of three years of case management experience and three years of management experience. The Case Management Supervisor must be located in Indiana to oversee case management staff. This individual must have experience in long term services and supports or the care of older adults.

Care Coordinators Shall be located in Indiana and licensed as applicable in Indiana. Care Coordinators must be (1) registered nurses in good standing, (2) have a Master's degree in social work, (3) possess a bachelor's degree in social work, psychology, special education, or counseling, and have at least a minimum of one (1) years of experience in providing case management services to individuals who are older adults and/or individuals with physical or developmental disabilities and/or individuals determined to have a serious mental illness (SMI), or (4) be a licensed practical nurse (LPN) with a minimum of three years of clinical experience with older adults. A portion of the Contractor's Care Coordinators shall have experience in behavioral health so that they may appropriately assist members with behavioral health conditions.

Service Coordinators The Contractor shall employ service coordinators located in Indiana. Service coordinators must be registered nurses or licensed practical nurses, have at least one (1) year of experience serving the program population, have bachelor's degrees, or associate's degrees with one (1) year of experience delivering healthcare/social services or case management, or at least two (2) or more years in care planning, care management, or delivering healthcare or social services. A portion of the Contractor's Service Coordinators shall have experience in behavioral health so that they may appropriately assist members with behavioral health conditions.

Transition Coordination Staff who is located in Indiana to support and oversee the initial and ongoing member transitions in and out of the various Indiana Medicaid programs, the Contractor's enrollment, and among care settings. The Transition Coordination Staff will assist with the planning and preparation for transitions and the follow-up care after transitions are completed. As an example, the Staff will aid members who lose nursing facility level of care or are ready for discharge from a nursing facility to ensure a successful discharge or transfer to another residential setting. The Transition Coordination staff shall include healthcare professionals working with the Member Advocate Coordinator and other member-focused departments of the plan to ensure continuity and coordination of care and member and provider communication through the initial transition, ongoing benefit plan, and MCE transfers. The Transition Coordination staff shall be responsible for ensuring the transfer and receipt of all outstanding prior authorization decisions, utilization management data, and clinical information such as prevention and wellness programs(s), care management and complex case management notes.

Board Certified Psychiatrist and Addiction Specialist part-time or on-call board certified psychiatrist and addiction specialist with qualifications and certification as outlined by ASAM for behavioral health utilization management activities.

Member Services Representatives a minimum of seventy (70) percent of whom are located in Indiana. The member services representatives shall coordinate communications between the Contractor and its members; respond to member inquiries; and assist all members regarding issues such as the Contractor's policies, procedures, general operations, benefit coverage, and

eligibility. Member services staff should have access to real time data for members, including eligibility status, benefit package, balance and transactions, primary medical provider (PMP) assignments and all service and utilization data. Member services staff shall have the appropriate training and demonstrate full competency before interacting with members.

Member Liaison who is a single point of contact and specifically responsible for coordination with Adult Protective Services (APS), the justice system, Member Support Services contractor, and the Long-Term Care (LTC) ombudsman, and shall be located in Indiana.

Member Marketing and Outreach Staff a minimum of seventy (70) percent of whom are located in Indiana. The member marketing and outreach staff shall manage marketing and outreach efforts for the [MLTSS Program Name] program.

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

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

Provider Representatives who serve this contract shall be located in Indiana and will develop the Contractor's network and coordinate communications between the Contractor and contracted and non-contracted providers, paying particular attention to educating and encouraging providers to participate in the [MLTSS Program Name] program and other Indiana Medicaid product lines to ensure continuity of care for members transitioning between programs. The Contractor shall have provider representatives exclusively dedicated to the LTSS and HCBS providers of the state.

Provider Claims Educator(s) who are located in Indiana and who facilitates the exchange of information between the grievances, claims processing, and provider relations systems. The primary functions of the Provider Claims Educator include: educating contracted and non-contracted providers (professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions, and electronic fund transfer; educating contracted and non-contracted providers on available Contractor resources such as provider manuals, website, fee schedules, etc.; interfacing with the Contractor's call center to compile, analyze, and disseminate information from provider calls; identifying trends and guiding the development and implementation of strategies to improve provider satisfaction; and frequently communicating with providers, including conducting on-site visits, to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices. Prior experience as an LTSS or HCBS provider or in a provider office is preferred.

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

Member and Provider Education/Outreach Staff who service this contract shall be located in Indiana and will promote health-related prevention and wellness education and programs; maintain member and provider awareness of the Contractor's programs, policies and procedures;

and identify and address barriers to an effective health care delivery system for the Contractor's members and providers. Certification Health Education Specialist is preferred.

Website Staff to maintain and update the Contractor's member and provider websites and member portal that are trained in ADA compliance to maintain and update the Contractor's member and provider websites.

2.4.4 Additionally Required Staff Positions

The Contractor is responsible for ensuring adequate staffing to meet the requirements of the Contract and the delivery of high quality, operationally efficient services. FSSA may set required staffing levels for contractors. FSSA may require additional staffing for Contractors who fail to maintain compliance with the performance metrics of the Contract. The Contractor shall adhere to the State approved staffing plan.

2.4.5 Staff Training and Qualifications

On an ongoing basis, the Contractor shall ensure that each staff person, including members of subcontractors' staff, has appropriate skills, education, and experience to fulfill the requirements of their position, as well as ongoing training (e.g., orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, management of IT systems, training on fraud and abuse and the False Claims Act, HIPAA, etc.). The Contractor shall provide initial and ongoing training and must ensure all staff are trained in the major components of the [MLTSS Program Name] program. Staff training shall include, but is not limited to:

- An overview of the [MLTSS Program Name] program & associated policies and procedures, and quality goals including updates whenever changes occur;
- Person-centered thinking
- Contract requirements and state and federal requirements specific to job functions;
- In accordance with 42 CFR 422.128, training on the Contractor's policies and procedures on advance directives;
- Initial and ongoing training on identifying and handling quality of care concerns;
- Cultural competency and health equity training, performed or created in conjunction with disability and aging led organizations;
- Training on fraud and abuse and the False Claims Act;
- Health Insurance Portability and Accountability Act (HIPAA) training;
- Management of IT systems;
- Clinical protocol training for all clinical staff;
- Utilization management staff shall receive ongoing training regarding interpretation and application of the Contractor's utilization management guidelines. The ongoing training shall, at minimum, be conducted on a quarterly basis and as changes to the Contractor's utilization management guidelines and policies and procedures occur;
- Evidence based assessment processes, person-centered planning, and population specific training relevant to all populations enrolled in the [MLTSS Program Name] program for all care managers and service coordinators. The Contractor shall also ensure all applicable subcontractors provide such training to their relevant staff;

- Training and education to understand abuse, neglect, exploitation, and prevention including the detection, reporting, investigation and remediation procedures and requirements; and
- Training for transportation, prior authorization and member services staff on the geography of the state and location of network service providers to facilitate the approval of services and recommended providers in the most geographically appropriate location.
- Training for the Contractor's Service Coordinators around self-direction including Participant-Directed Attendant Care Services and future iterations of the program and the role and responsibilities including financial administration and brokerage functions.

The State-developed [MLTSS Program Name] MCE Policies and Procedures Manual, may be periodically amended by FSSA, shall be provided to the Contractor's entire staff and any subcontractors providing services under the Contract. The MCE Policies and Procedures Manual shall be incorporated into all training programs for staff responsible for providing services under the Contract. Training materials must be updated on a regular basis to reflect any program changes. The Contractor shall maintain documentation to confirm staff training, curriculum, schedules, and attendance, and shall provide this information to FSSA upon request and during regular on-site visits. For its utilization management staff the Contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by FSSA.

2.5 Debarred Individuals

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

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

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

The relationships include directors, officers or partners of the Contractor, persons with beneficial ownership of five percent (5%) or more of the Contractor's equity, or persons with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

In accordance with 42 CFR 438.610, which prohibits affiliations with individuals debarred by Federal agencies, if FSSA finds that the Contractor is in violation of this regulation, FSSA will notify the Secretary of noncompliance and determine if this Contract will be terminated.

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

The Contractor shall be required to disclose to the OMPP PI Section information required by 42 CFR 455.106 regarding the Contractor's staff and persons with an ownership/controlling interest in the Contractor that have been convicted of a criminal offense related to that person's involvement in Medicare/Medicaid or Title IX programs.

2.6 FSSA Meeting Requirements

FSSA conducts meetings and collaborative workgroups for the [MLTSS Program Name] program. The Contractor shall comply with all meeting requirements established by FSSA and is expected to cooperate with FSSA and/or its contractors in preparing for and actively participating in these meetings.

The Contractor shall also participate in meetings and proceedings with external entities as directed by FSSA, including but not limited to, the DUR Board, MHQAC, Medicaid Advisory Committee, Therapeutics Committee, Indiana Psychotropic Medication Advisory Committee and legislative hearings. FSSA may also require the participation of subcontracted entities in other instances, as determined necessary. Attendance at all meetings shall be at no additional cost to FSSA. FSSA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary.

At Contract initiation, FSSA will conduct a series of orientation sessions. The Contractor shall ensure the attendance of appropriate staff at each session based on topics to be discussed. During Contract implementation, the Contractor shall meet with FSSA on a State approved schedule to coordinate a smooth transition and implementation. The Contractor should be prepared to meet at least weekly.

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

2.7 Financial Stability

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

FSSA and the Indiana Department of Insurance (IDOI) will monitor the Contractor's financial performance. FSSA will include IDOI findings in their monitoring activities. FSSA shall be copied on required filings with IDOI, and the required filings shall break out financial information for the [MLTSS Program Name] line of business separately. The financial performance reporting requirements are listed in Section 10.1 and are further described in the [MLTSS Program Name] MCE Reporting Manual, which shall be provided following the Contract award date.

2.7.1 Solvency

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

The Contractor shall comply with the federal requirements for protection against insolvency pursuant to 42 CFR 438.116, which sets solvency standards for managed care entities. These requirements provide that, unless the Contractor is a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act), the Contractor shall:

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

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

2.7.2 Insurance Requirements

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

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

2.7.3 Reinsurance

The Contractor shall purchase reinsurance from a commercial reinsurer and shall establish reinsurance agreements meeting the requirements listed below. The Contractor shall submit new policies, renewals, or amendments to FSSA for review and approval at least one hundred and twenty (120) calendar days before becoming effective.

- Agreements and Coverage
    - The attachment point shall be equal to or less than $500,000 and shall apply to all services, unless otherwise approved by FSSA. The Contractor electing to establish commercial reinsurance agreements with an attachment point greater than $500,000 must provide a justification in its proposal or submit justification to FSSA in writing at least one hundred and twenty (120) calendar days prior to the policy renewal date or date of the proposed change. The Contractor must receive approval from FSSA before changing the attachment point.
    - The Contractor’s co-insurance responsibilities above the attachment point shall be no greater than twenty percent (20%).
    - Reinsurance agreements shall transfer risk from the Contractor to the reinsurer.
    - The reinsurer's payment to the Contractor shall depend on and vary directly with the amount and timing of claims settled under the reinsured contract. Contractual features that delay timely reimbursement are not acceptable.
    - The Contractor shall obtain continuation of coverage insurance (insolvency insurance) to continue plan benefits for members until the end of the period for which premiums have been paid. This coverage shall extend to members in acute care hospitals or nursing facility settings when the Contractor’s insolvency occurs during the member’s inpatient stay. The Contractor shall continue to reimburse for its member’s care under those circumstances (i.e., inpatient stays) until the member is discharged from the acute care setting or nursing facility.
- Requirements for Reinsurance Companies
    - The Contractor shall submit documentation that the reinsurer follows the National Association of Insurance Commissioners' (NAIC) Reinsurance Accounting Standards.

- The Contractor shall be required to obtain reinsurance from insurance organizations that have Standard and Poor's claims-paying ability ratings of "AA" or higher and a Moody's bond rating of "A1" or higher, unless otherwise approved by FSSA.

- Subcontractors

    - Subcontractors' reinsurance coverage requirements must be clearly defined in the reinsurance agreement.

    - Subcontractors should be encouraged to obtain their own stop-loss coverage with the above-mentioned terms.

    - If subcontractors do not obtain reinsurance on their own, the Contractor is required to forward appropriate recoveries from stop-loss coverage to applicable subcontractors.

2.7.4 Financial Accounting Requirements

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

In accordance with 42 CFR 455.100-104, which defines ownership and control percentages and requires disclosure thereof, the Contractor shall notify FSSA of any person or corporation with five percent (5%) or more of ownership or controlling interest in the Contractor and shall submit financial statements for these individuals or corporations. Additionally, annual audits shall include an annual actuarial opinion of the Contractor's incurred but not received claims (IBNR) specific to the [MLTSS Program Name] program.

Authorized representatives or agents of the State and the federal government shall have access to the Contractor's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit and/or reproduction. In addition, the Contractor shall file with the State Insurance Commissioner the financial and other information required by the IDOI.

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

The Contractor shall maintain financial records pertaining to the Contract, including all claims records, for three (3) years following the end of the federal fiscal year during which the Contract is terminated, or when all state and federal audits of the Contract have been completed, whichever is later, in accordance with 45 CFR 74.53, which sets retention and access requirements for

records. Financial records should address matters of ownership, organization, and operation of the Contractor's financial, medical and other record keeping systems. However, accounting records pertaining to the Contract shall be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the Contract if the litigation has not terminated within the three (3) year period.

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

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

2.7.5 Reporting Transactions with Parties of Interest

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

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

- Any director, officer, partner or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of

trust, note or other interest secured by, and valuing more than five percent (5%) of the HMO; and, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

- Any entity in which a person described in the paragraph above is a director or officer; is a partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the HMO;

- Any person directly or indirectly controlling, controlled by or under common control with an HMO; and

- Any spouse, child, or parent of an individual described above.

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

- Any sale, exchange, or lease of any property between the HMO and a party in interest;

- Any lending of money or other extension of credit between the HMO and a party in interest; and

- Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

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

- The name of the party in interest for each transaction;

- A description of each transaction and the quantity or units involved;

- The accrued dollar value of each transaction during the fiscal year; and

- Justification of the reasonableness of each transaction.

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

If the Contract is an initial contract with FSSA, but the Contractor has operated previously in commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed within thirty (30) days of the initial contract start date. If the Contract is being renewed or extended, the Contractor shall disclose information on business transactions which occurred during the prior contract period within thirty (30) days of the end of each contract year. The business transactions which shall be reported are not limited to transactions related to serving the Medicaid enrollment, that is, all of the Contractor's business transactions shall be reported.

2.7.6 Compensation

The method of compensation under this Contract will be capitation payments and payments from liable third parties, as specified and defined within this Contract, and appropriate laws, regulations, and policies [42 CFR 438.6(b)(1)]. The Contractor will be paid a capitation for all prospective coverage member months, including partial member months as described in Exhibit

5. Final capitation rates are identified and developed, and payment is made in accordance with 42 CFR 438.3(c).

Subject to the availability of funds, payments shall be made to the Contractor in accordance with the terms of this Contract provided that the Contractor's performance is compliant with the terms and conditions of this Contract. The State reserves the option to make payments to the Contractor by wire or National Automated Clearing House Association (NACHA) transfer and will provide the Contractor at least thirty (30) days' notice prior to the effective date of any such change.

Where payments are made by electronic funds transfer, Indiana shall not be liable for any error or delay in transfer, nor indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor.

An error discovered by the State, with or without an audit, in the amount of fees paid to the Contractor will be subject to adjustment or repayment via a recoupment from future payment(s) to the Contractor, or by making an additional payment to the Contractor. When the Contractor identifies an overpayment, FSSA must be notified and reimbursed within thirty (30) days of identification [42 CFR 438.608(c)(3)].

No payment due to the Contractor by the State may be assigned or pledged by the Contractor. This section shall not prohibit the State at its sole option from making payment to a fiscal agent hired by the Contractor.

The Contractor will be denied payment for newly enrolled members when, and for so long as, payment for those members is denied by CMS under 42 CFR 438.730(e) [42 CFR 438.726(b), 42 CFR 438.700(b)(1) - (6), 42 CFR 438.730(e)(1)(i), 42 CFR 438.730(e)(1)(ii), Section 1903(m)(5)(B)(ii) of the Social Security Act].

All funds received by the Contractor pursuant to this Contract shall be separately accounted for in accordance with generally accepted accounting principles. The Contractor shall develop and maintain internal controls and systems to separately account for both [MLTSS Program Name]-related revenue and expenses and non-[MLTSS Program Name]-related revenue and expenses by type and develop and maintain internal controls to prevent and detect fraud, waste, and program abuse. The Contractor shall separately account for all funds received under this Contract as required in the MCE Reporting Manual. [42 CFR 438.3(m)].

2.7.6.1 Capitation Payments

Actuaries establish the capitation rates using practices established by 42 CFR Part 438 and complying with standards maintained by the Actuarial Standards Board. The following data shall be provided to the actuaries for the purpose of setting and rebasing and/or updating the capitation rates:

- Utilization and unit cost data derived from fully adjudicated and approved encounters, as well as individual encounter level detail as needed
- Both unaudited and audited financial statements reported by the Contractors
- HCBS and Institutional inflation trends
- Indiana Fee-For-Service (FFS) schedule pricing adjustments (if applicable)
- Market Basket Inflation Trends

- Historical and projected enrollment by risk group
- Programmatic or Medicaid covered service changes that affect reimbursement
- Additional administrative requirements for the Contractor
- Other changes to medical practices that affect reimbursement
- Functional assessment data for NF and HCBS enrollees
- Supplemental financial reporting requested from the Contractors

Rates shall be adjusted to best match payment to risk. This further ensures the actuarial basis for the capitation rates. The following are examples of risk factors that may be included:

- Reinsurance,
- Medicare enrollment,
- Geographic Service Area adjustments,
- Nursing Facility and HCBS member mix and level of need (based on functional assessments),
- Chronic conditions and demographics of members enrolled with the Contractor,
- Member share of cost amounts,
- Amounts paid by third parties, and
- Supplemental information requested from Contractors

For services or pharmaceuticals, in instances in which Indiana has specialty contracts or legislation/policy limits the allowable reimbursement, the amount to be used in the capitation rate setting process and reconciliations will be the lesser of the contracted/mandated amount or the Contractor paid amount.

The above information is reviewed by the actuaries in renewal years to determine if adjustments are necessary. A Contractor may cover services that are not covered under the State Plan section 1915(c), 1915(I), 1915(j), or 1915(k) of the Social Security Act waiver; however, those services are not included in the data provided to actuaries for setting capitation rates in accordance with 42 CFR 438.6(e).

2.7.7 Medical Loss Ratio

On an annual basis, the Contractor shall calculate and submit to FSSA its Medical Loss Ratio (MLR) as described in the MCE Reporting Manual for the [MLTSS Program Name]. The Contractor must attest to the accuracy of the MLR calculation in compliance with 42 CFR 438.8. In addition, the State provides the following clarifications:

1. The MLR calculation shall be performed separately for each MLR reporting year.

2. The MLR calculation shall be performed separately for each program. The MLR for the [MLTSS Program Name] program shall be calculated separately from other managed care programs.

3. Expenses shall be appropriately pro-rated among expense types, programs and populations and allocated as required in 42 CFR 438.8(g). The state will provide guidance on allowable quality expenses, such as care management and service coordination, which the contractor shall follow.

4. For each MLR reporting year, a preliminary calculation will be performed with six months of incurred claims run-out, and a final calculation will be performed with 18 months of incurred claims run-out.

5. Incurred claims reported in the MLR should relate only to members who were enrolled with the MCE on the date of service, based on data and information available on the reporting date. (Claims for members who were retroactively disenrolled should be recouped from providers and excluded from MLR reporting).

6. Under Sub-Capitated or Sub-Contracted arrangements, the MCE may only include amounts actually paid to providers for covered services and supplies as incurred claims. The non-benefit portion of sub-capitated and sub-contracted payments should be excluded from incurred claims. The MCE should ensure all subcontracts provide for sufficient transparency to allow for this required reporting.

The Contractor shall maintain, at a minimum, a MLR of ninety-three percent (93%) for its [MLTSS Program Name] line of business.

FSSA considers only the following items as allowable to be considered health quality improvement expenditures under 42 CFR 438.8 and 42 CFR 158.150:

- Care management, complex care management, and service coordination as defined in Section 4.0 of this contract

- Contractor assistance with member transitions of care, excluding utilization management such as prior authorization, concurrent review, and retrospective review

- Quality management, excluding cost of administering member incentives

- Medical analytics and health information technology, only to the extent that the analytics and technology are used to support care management, risk stratification, or a specific quality initiative

- Member and provider quality incentives, if they are not already reflected in claims

FSSA shall recoup excess capitation paid to the Contractor in the event that the Contractor's MLR is less than ninety-three percent (93%) for the [MLTSS Program Name] line of business.

Any retroactive changes to capitation rates after the contract year end are required to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted, a new report incorporating the change will be required to be submitted within thirty (30) days of the capitation rate adjustment payment to the Contractor.

2.8 Supplemental Payments and Directed Payments

2.8.1 Hospital Assessment Fee

Hospital Assessment Fee (HAF) payments will be integrated into capitation rates. Contractors are required to pay HAF hospitals at the enhanced Medicaid rates for HAF eligible services detailed below:

1. HAF eligible hospitals
    i. Contracted providers: MCEs shall pay one hundred percent (100%) of the enhanced (HAF) rates, which is one hundred percent (100%) of the fee schedule rate multiplied by the HAF factor OR one hundred percent (100%) of the Inpatient APR DRG rate multiplied by the HAF factor.

    ii. Non-contracted providers: MCEs shall pay ninety-eight percent (98%) of the enhanced (HAF) rates, which is ninety-eight percent (98%) of the fee schedule rate multiplied by the HAF factor OR ninety-eight percent (98%) of the Inpatient APR DRG rate multiplied by the HAF factor.
2. Non-HAF eligible hospitals
    iii. Contracted providers: MCEs shall pay the amount negotiated with the contracted provider. One hundred percent (100%) of the Medicaid APR DRG rates for Inpatient and one hundred percent (100%) of the Medicaid OP Fee Schedule.

    iv. Non-contracted providers: MCEs shall pay the following: Ninety-eight percent (98%) of the Medicaid APR DRG rates for Inpatient and ninety-eight percent (98%) of the Medicaid OP Fee Schedule.

2.8.2 Physician Faculty Access to Care (PFAC) Program

Enhanced reimbursement is authorized under the Indiana Physician Faculty Access to Care (PFAC) program. Payments for the PFAC program will be integrated into capitation rates.

The program provides enhanced reimbursement for physician services rendered to all of the non-dual Medicaid populations, including those served under risk-based managed care programs, by qualified faculty physicians or other eligible practitioners, as defined in the State Plan.

Eligible physicians and practitioners must be employed by a hospital system that participates in the PFAC program (currently either Indiana University Health, Inc. (IU Health Physicians) or the Sidney and Lois Eskenazi Hospital (Eskenazi Medical Group), also known as the Health and Hospital Corporation of Marion County. Other hospital systems have expressed interest in the PFAC program and could potentially be added to the program in the future.

The physicians must be affiliated with an in-state medical school, licensed by the State of Indiana, and enrolled as an Indiana Medicaid provider. The program also applies to non-physician staff such as nurses, physician assistants, midwifes, social workers, psychologists, and optometrists.

Eligible physicians and non-physician staff are eligible for reimbursement at up to the average commercial rate (ACR), with actual enhanced reimbursement subject to annual performance on specified access metrics. Performance payout levels are calculated separately for IU Health Physicians and Eskenazi Medical Group, respectively.

The Contractor is responsible for ensuring PFAC payments are delivered to eligible providers whether in or out of network. The PFAC payments are currently made as part of normal claim processing and require the contractor to support a separate fee schedule for use in reimbursing the PFA eligible providers. Options for alternate payment approaches are under consideration by the State.

2.8.3 Nursing Facility Supplemental Payments

Payments for the Nursing Facility Upper Payment Limit (UPL) supplemental program will not be integrated into the capitation rates. Payments will be made through either pass-through payments or state-directed payments.

The majority of Indiana's nursing facilities participate in the UPL program along with the Non-State Government Owned (NSGO) hospitals that own or operate the nursing facilities. The UPL program is funded at a level that represents the difference between Medicare nursing facility rates and Indiana Medicaid base rates for nursing facility residents covered by Medicaid in a given year. The NSGO or / operator hospitals fund the non-federal portion of the UPL funding through Inter-Governmental Transfers (IGTs) to the State.

The State will be responsible for calculating the amount of the quarterly UPL payments due each quarter and for collecting the IGT payments from the NSGOs. There are two sets of payments anticipated for each quarter, one UPL payment to each NSGO and a second quality based UPL payment to each nursing facility.

The Contractor is responsible for making quarterly payments to NSGOs and nursing facilities as directed by the State.

2.8.4 LTSS and HCBS Minimum Fee Schedule

In and out of network Skilled Nursing Facility, Home Health, Hospice and HCBS providers shall be reimbursed at no less than Fee for Service rates (i.e., a rate established by OMPP) for the first five years of the program.

2.9 Subcontracts

The term "subcontract(s)" includes contractual agreements between the Contractor and health care providers or other ancillary medical providers. Additionally, the term "subcontract(s)" includes contracts between the Contractor and another prepaid health plan, physician-hospital organization, pharmacy benefits manager, dental benefits manager, transportation broker, or any entity that performs delegated activities related to the Contract and any administrative entities not involved in the actual delivery of medical care.

FSSA shall approve all subcontractors and any change in subcontractors or material change as outlined in Section 2.9 to subcontracting arrangements. FSSA may waive its right to review subcontracts and material changes to subcontracts. Subcontracts with entities that are located outside of or will perform work outside of the United States and Territories of the United States are prohibited. The State encourages the Contractor to subcontract with entities located in the State of Indiana.

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

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

The Contractor shall provide that all subcontracts with other prepaid health plans, physician hospital-organizations, pharmacy benefits manager, dental benefits manager, transportation broker or any other

entity that performs delegated activities related to the Contract and any administrative entities not involved in the actual delivery of medical care, indemnify and hold harmless the State of Indiana, its officers and employees from all claims and suits, including court costs, attorney's fees and other expenses, brought because of injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of the Contractor and/or the subcontractors. This indemnification requirement does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

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

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

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance
- Incurred but not received (IBNR) estimates

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

The Contractor shall comply with 42 CFR 438.230, 42 CFR 434.6 and the following subcontracting requirements:

- The Contractor shall obtain the explicit approval of FSSA before subcontracting any portion of the program's requirements except for network healthcare providers or ancillary medical providers. Subcontractors may include, but are not limited to a pharmacy benefits manager, dental benefits manager, transportation broker, behavioral health organizations (BHOs) and Physician Hospital Organizations (PHOs). The Contractor may not subcontract medical utilization management activities, but pharmacy utilization management activities may be subcontracted. The Contractor shall give FSSA a written request and submit a draft contract or model provider agreement at least ninety (90) calendar days prior to the use of a subcontractor. The request must include a written plan on continuity of services during any transition of services. If the Contractor makes subsequent changes to the duties included in the subcontractor contract, it shall notify FSSA ninety (90) calendar days prior to the revised contract effective date and submit the amendment for review and approval. FSSA has sixty (60) days to complete a review and provide an approval or denial on the use of the subcontractor to the Contractor. FSSA must approve changes in vendors for any previously approved subcontracts.
- The Contractor must seek approval from the State for utilizing vendors for member outreach or to provide direct services, medical or behavioral care to members. The Contractor is required to provide a report sixty (60) days after the end of each calendar year listing all such agreements. The report should include method of identifying members for the vendor, services provided, number of members for which each contracted vendor provided services, and standard demographics for the members who received the services.

- The Contractor may not advertise or announce the new subcontractor relationship prior to FSSA's approval of the subcontract. For subcontractors which result in a material change triggering member or provider notice, the ninety (90) day FSSA review period for the subcontract, thirty (30) day period for document review, and thirty (30) or forty-five (45) day notice requirement may not run concurrently.
- The Contractor shall evaluate prospective subcontractors' abilities to perform delegated activities prior to contracting with the subcontractor to perform services associated with the [MLTSS Program Name] program.
- The Contractor shall have a written agreement in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement shall comply with all the State of Indiana statutes and will be subject to the provisions thereof. The subcontract cannot extend beyond the term of the State's Contract with the Contractor.
- The Contractor shall collect performance and financial data from its subcontractors and monitor delegated performance on an ongoing basis and conduct formal, periodic, and random reviews, as directed by FSSA. The Contractor shall incorporate all subcontractors' data into the Contractor's performance and financial data for a comprehensive evaluation of the Contractor's performance compliance and identify areas for its subcontractors' improvement when appropriate. The Contractor shall take corrective action if deficiencies are identified during the review.
- All subcontractors shall fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract. In addition, all subcontractors shall fulfill the requirements of the Contract (and any relevant amendments) that are appropriate to any service or activity delegated under the subcontract.
- The Contractor shall submit a plan to the State on how the subcontractor will be monitored for debarred employees.
- The Contractor shall submit a subcontractor oversight and monitoring plan to the State for review and approval during Readiness Review and annually within sixty (60) days.
- The Contractor shall be responsible for the administration and management of all aspects of this Contract including all subcontracts/subcontractors. The Contractor shall ensure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor for purposes of this Contract without prior written approval of the Contractor. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the Contractor to the State to ensure that all activities under this Contract are carried out in compliance with the Contract.
- Should the Contractor have a subcontract arrangement for utilization management activities for pharmacy, the Contractor shall ensure, consistent with 42 CFR 438.210(e) that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).
- If the Contractor subcontracts with an entity specifically to conduct care coordination, care management, or service coordination functions, including comprehensive assessments or reassessments and/or developing or authorizing plans of care, such subcontractor shall not provide any direct long-term services and supports. This does not preclude nursing facilities or hospitals contracted with the Contractor to deliver services from completing and submitting pre-admission evaluations. The care coordinators, care managers, or service coordinators must be in Indiana. FSSA encourages Contractors who choose to subcontract in this area to consider community-based disability and community-based aging organizations.

- The Contractor shall provide instruction for all direct service subcontractors and providers regarding the Contractor's written procedure for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, enrollees with Limited English Proficiency. The Contractor shall provide instruction to direct service subcontractors and providers on disability access, person-centered thinking, 42 CFR 441.301(c) settings rule compliance, and ADA compliance.
- The Contractor and its subcontractors shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations, and as amended. The Contractor shall require all its subcontractors to adhere to HIPAA standard transaction requirements.
- The Contractor shall comply with all subcontract requirements specified in 42 CFR 438.230, which contains federal subcontracting requirements. All subcontracts, provider contracts, agreements or other arrangements by which the Contractor intends to deliver services required under the Contract, whether or not characterized as a subcontract under the Contract, are subject to review and approval by FSSA and must be sufficient to assure the fulfillment of the requirements of 42 CFR 434.6, which addresses general requirements for all Medicaid contracts and subcontracts. FSSA may waive its right to review subcontracts, provider contracts, agreements or other arrangements. Such waiver shall not constitute a waiver of any subcontract requirement.

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

FSSA reserves the right to audit the Contractor's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. FSSA may require corrective actions and will assess liquidated damages, as specified in Exhibit 2 Contract Compliance and Pay for Outcomes, for non-compliance with reporting requirements and performance standards.

The Contractor is prohibited from subcontracting with providers who have been excluded from the federal government or by the Indiana Health Coverage Program (IHCP) for fraud or abuse. The Contractor shall be responsible for checking the lists of providers currently excluded by the state and the federal government every thirty (30) calendar days. The federal list is available at: http://exclusions.oig.hhs.gov. As described in Section 6.0, all network providers must be IHCP enrolled providers. The Contractor shall ensure when the IHCP disenrolls a provider, the Contractor also terminates the provider agreement for the [MLTSS Program Name] program.

If the Contractor uses subcontractors, the subcontractors shall meet the same requirements as the Contractor including requirements related to experience with LTSS and/or experience with older adults where noted. And the Contractor shall demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The Contractor shall require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors. The Contractor should include in the request for approval of any direct service or care provider a summary of the subcontractor's experience in providing such service and/or care.

While the Contractor may choose to subcontract claims processing functions, or portions of those functions, with a state-approved subcontractor, the Contractor shall demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral providers, and will not result in confusion to the provider community about where to submit claims for payments. For example, the Contractor may elect to establish one post office box address for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, it is

the Contractor's responsibility to ensure that the subcontracting organizations forward claims to the appropriate processing entity. Use of a method such as this will not lengthen the timeliness standards discussed in Section 9.7. In this example, the definition of "date of receipt" is the date of the claim's receipt at the post office box.

The Contractor and its subcontractors shall maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under this Contract. As required by 42 CFR 438.3(h), the Contractor shall allow duly authorized agents of the state, CMS, the Office of Inspector General, the Comptroller General and their designees, at any time, to inspect and audit any records or documents of the Contractor or its subcontractors, and may, at any time, inspect premises, physical facilities, and equipment where Medicaid related activities or work is conducted. The right to audit under this section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. Copies shall be furnished at no cost to the State if requested.

2.10 Confidentiality of Member Medical Records and Other Information

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

2.11 Internet Quorum (IQ) Inquiries

The Contractor shall respond to IQ inquiries within the timeframe set forth by FSSA. When forwarding an IQ inquiry to the Contractor for a response, FSSA shall designate that the inquiry is an IQ inquiry and will identify when the Contractor's response is due. IQ inquiries typically include member, provider and other constituent concerns and require a prompt response. Failure by the Contractor to provide a timely and satisfactory response to IQ inquiries will subject the Contractor to the liquidated damages set forth in Exhibit 2.

2.12 Material Change to Operations

A material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect the Contractor's membership or provider network.

Prior to implementing a material change in operation, the Contractor shall submit a request to FSSA for review and approval at least sixty (60) calendar days in advance of the effective date of the change. The request must contain, at minimum, information regarding the nature of the change, the rationale for the change, and the proposed effective date. The contractor may be required, at the direction of FSSA, to communicate material changes to members or providers at least thirty (30) days prior to the effective date of the change.

2.13 Future Program Guidance

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

2.14 Conflict of Interest

The Contractor shall ensure compliance with applicable laws and conflict of interest safeguards in accordance with 42 CFR 438.3(f). When a Contractor refers a member to a provider owned by the Contractor, the Contractor shall notify the member of the conflict of interest.

2.15 Capitation Related to a Vacated Program

Should any part of the scope of work under this contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must not implement that part after the effective date of the loss of program authority. The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor received capitation payments that included costs specific to a program or activity no longer authorized by law prior to the effective date of the loss of authority for work that would be performed after that effective date, the State must adjust those capitation payments to ensure that previous reimbursement of costs specific to the program or activity no longer authorized is returned to the State and that costs specific to the program or activity no longer authorized are no longer paid by the State after the effective date of the loss of program authority. Capitation payments received prior to the effective date of loss of program authority that included costs for work specific to the program or activity that is no longer authorized, but that was performed prior to that effective date, may be retained by the Contractor and need not be returned to the State.

2.16 Maintenance of Records

The Contractor shall adhere to the FSSA Records Retention and Disposition Schedule included in the Bidders' Library, including any and all updates to the FSSA Records Retention and Disposition Schedule.

2.17 Maintenance of Written Policies and Procedures

The Contractor shall develop and maintain written policies and procedures for each functional area in compliance with the Code of Federal Regulations, Indiana Code, Indiana Administrative Code, FSSA Policy and Procedure Manuals and the Contract. Written guidelines shall be maintained for developing, reviewing and approving all policies and procedures. The Contractor shall review all policies and procedures at least annually to ensure they reflect current practice and shall be updated as necessary. Reviewed policies shall be signed and dated. All medical and quality management policies shall be reviewed and approved by the Contractor's Medical Director. FSSA has the right to review all Contractor policies and procedures. Should the FSSA determine a Contractor policy requires revision, the Contractor shall work with the FSSA to revise within the timeframes specified by the State. If the FSSA determines the Contractor lacks a policy or process required to fulfill the terms of the Contract, the Contractor must adopt a policy or procedure as directed by FSSA.

2.18 Participation in Readiness Review

The Contractor shall undergo and must pass a two (2)-phase readiness review process and be ready to assume responsibility for contracted services upon the Contract effective date as described in further detail in the Readiness Review requirements and documentation. The Contractor shall maintain a detailed implementation plan, to be approved by FSSA, which identifies the elements for implementing the proposed services which include, but are not limited to, the Contractor's tasks, staff responsibilities, timelines and processes that will be used to ensure contracted services begin upon the Contract effective date. In addition to submitting the implementation plan with the proposal, the Contractor may be required to submit a revised implementation plan for review as part of the Readiness Review.

2.19 Dissemination of Information

Upon request of the State, the Contractor shall distribute information prepared by FSSA, its designee, or the Federal Government to its members.

2.20 Access to Premises and Information

2.20.1. Access to Premises

The Contractor shall allow duly authorized agents or representatives of the state or federal government, including CMS, the HHS Inspector General, the Comptroller General, or their designees or representatives, at any time, access to the Contractor's premises, physical facilities, and equipment, the Contractor providers' premises, physical facilities, and equipment or the Contractor subcontractors' premises, physical facilities, and equipment to inspect, audit, monitor, examine, excerpt, transcribe, copy or otherwise evaluate the performance of the Contractor's or subcontractors' contractual activities and shall forthwith produce all records or documents, including but not limited to financial, member or administrative records, books, contracts, and computer or other electronic systems requested as part of such review or audit.

The State or federal government may inspect and audit any financial, care management, member, administrative or other records of the Contractor, its providers, or its subcontractors. There shall be no restrictions on the right of the state or the federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and the reasonableness of their costs or for any purpose the State or federal government deems necessary for administration or operation of the program. When requested by the State or federal government, the Contractor shall provide access to electronic records in any circumstance when it uses electronic records.

In the event right of access is requested under this section, the Contractor, provider, or subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The State or federal government may perform off-site audits or inspections to ensure that the Contractor is compliant with contract requirements.

All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the Contractor's, provider's, or subcontractor's activities. All information so obtained will be accorded confidential treatment as provided under applicable law.

2.20.2 Access to and Audit of Contract Records

Throughout the duration of this contract, and after termination of this contract, the Contractor shall provide duly authorized agents of the state or federal government access to all records and material relating to the contract's provision of and reimbursement for activities contemplated under this contract. The rights of access in this paragraph are not limited to the required retention period but shall last as long as records are retained, if longer. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of this contract. All information so obtained will be accorded confidential treatment as provided under applicable law. The rights to access, inspect, and audit premises and contract records described in Section 6.10 Medical Records exist for seven (7) years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, these access and audit rights may be exercised at any time.

2.21 Integration and Alignment of Medicare and Medicaid

Roughly 80% of Indiana's [MLTSS Program Name] population will be dually-eligible for both Medicare and Medicaid. The State has identified the alignment and integration of these two programs in [MLTSS Program Name] as key drivers to remove barriers to care as well as improve outcomes for dually-eligible members in [MLTSS Program Name].

Integration refers to a delivery system that provides the full array of Medicaid and Medicare to drive increased levels of care coordination and improved health outcomes.

Alignment refers to the identification and elimination of conflicting requirements, competing incentives, and system gaps between the Medicare and Medicaid programs to reduce administrative burden and streamline policies and operations.

The Contractor agrees to maintain an ongoing commitment to work with FSSA and all relevant Indiana stakeholders to identify and promote the continued integration and alignment of Medicare and Medicaid benefits, processes, and systems for its [MLTSS Program Name] enrollees consistent with State [MLTSS Program Name] vision and goals.

[MLTSS Program Name] will support a coordinated and integrated experience from the perspective of dually-eligible members, which would include, but is not limited to, the assessments and care coordination processes that span Medicaid and Medicare.

The Contractor agrees to cooperate fully with all State efforts to streamline the administration of Medicaid and Medicare programs—which may include, but is not limited to, readiness reviews, quality and outcomes monitoring, member enrollment, member marketing materials, and grievance and appeals processes.

2.21.1 Coordination with Medicare Generally

The Contractor shall coordinate all Medicare and Medicaid services for its full-benefit dually-eligible members. To the greatest extent possible, this shall include all reasonable efforts to coordinate care for dually-eligible members regardless of Medicare service delivery system or Medicare plan benefit package—this includes traditional Medicare, unaligned Medicare Advantage plans, Chronic Conditions Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs).

The Contractor shall ensure that services covered and provided pursuant to this contract are delivered without charge to members who are dually-eligible for Medicare and Medicaid services.

The Contractor is responsible for providing medically necessary Medicaid covered services to members who are also eligible for Medicare if the service is not covered by Medicare.

The Contractor shall engage with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of dually-eligible members.

The Contractor shall coordinate with all relevant state and social service agencies and community-based organizations (CBOs) as needed to better identify and address both the medical and social needs of the member. The Contractor shall establish systems and processes to effectively refer and connect members to these agencies.

The Contractor shall provide continued member, provider, and staff education and assistance pertaining to Medicare and Medicaid and their interaction; available Medicare and Medicaid partners and resources; and the care experience of dually-eligible members. This should include, but is not limited to:

1. Member education and resources such as:
    - An explanation of all Medicare and Medicaid benefits available to the member;
    - Assistance in coordinating the Medicare and Medicaid services that are available to the member;
    - The benefit of enrolling in a Medicare Part D plan with a zero copay.
    - A dedicated help line to take member phone calls and answer member questions about Medicare coverage, including those related to the contactor's aligned D-SNP plan.

2. Provider education that covers at a minimum:
    - Dual-eligibility in Indiana for Medicare and Medicaid
    - The care experience of dually-eligible members in Indiana
    - Coordination of services and benefits for dually-eligible members, which should include, but is not limited to, billing and claim submission requirements

3. New care coordinator training on Medicaid and Medicare that covers at a minimum:
    - An introduction to all Indiana Medicaid services, including covered physical and behavioral health services and long-term services and supports (LTSS), processes for authorizing such services, as applicable; expectations for the integration of LTSS service coordinators with the Interdisciplinary Care Team and LTSS service planning with the care planning and delivery for individuals enrolled in [MLTSS Program Name] and the care coordinator's role and responsibility in facilitating access to other Indiana Medicaid covered benefits; and
    - An introduction to Medicare services, including those provided by the Contractor's aligned D-SNP, the aligned D-SNP's State Medicaid Agency Contract (SMAC) and Model of Care (MOC), and the coordination of care for dually-eligible members;

The Contractor shall ensure its systems and business processes shall support an integrated approach to care coordination and service delivery across Medicare and Medicaid programs. This includes the capacity to receive and load all Medicare claims data, including data from its aligned D-SNP, as well as Medicare claims data made available by the state, into its relevant case management systems and processes. This data should be demonstrably accessible for the purposes of care coordination and to support the coordination of members' Medicare and Medicaid benefits.

The Contractor shall be required to demonstrate integration of all data and information into relevant systems and processes and accessibility by Contractor staff to use that data and information to facilitate effective coordination of Medicare and Medicaid benefits for the Contractor's dually-eligible members and support state integration and alignment goals.

2.21.2 Dual Eligible Special Needs Plan (D-SNPs) Requirements and Coordination

The Contractor shall execute an annual State Medicaid Agency Contract (SMAC) that will enable it to operate a D-SNP in the state effective January 1, 2024. The SMAC agreement will include CMS-required elements as well as State-specific additions. The SMAC agreement shall be renewed annually and will be subject to state review and revision to ensure the Contractor and its companion DSNP achieve the highest possible level of coordination and alignment of Medicare and Medicaid benefits.

The Contractor shall obtain Centers for Medicare & Medicaid Services (CMS) approval to operate a Dual Eligible Special Needs Plan (D-SNP) in Indiana by or before January 1, 2024 and demonstrate sufficient readiness at [MLTSS Program Name] go-live in the first quarter of 2024.

At go-live and ongoing, the Contractor D-SNP shall:

- Operate an exclusively aligned plan that is limited to full-benefit dually eligible (FBDE) enrollment;
- Offer a separate plan benefit package that enrolls only partial-dually eligible Medicaid enrollees (QMB-only, SLMB-only, QI, QDWI);
- Offer a separate plan benefit package that enrolls only full-benefit dually eligible Medicaid enrollees (QMB+, SLMB+, other FBDE) under sixty (60) years of age who are not eligible for [MLTSS Program Name];
- Maintain a statewide service area that operates in all Indiana counties;
- Have obtained prior CMS approval for default enrollment of members from their aligned [MLTSS Program Name] Medicaid plan upon them first becoming eligible for Medicare;
- Maintain a 3-star quality rating or above. The State will review these ratings annually as part of its quality review process.
- Meet SMAC contract requirements. Failure may result in FSSA will assessing authorized remedies for the Contractor's non-compliance as listed in Exhibit 2.

The Contractor shall designate a single point of coordination on the member's Interdisciplinary Care Team (ICT) for its dually-eligible members enrolled in its aligned D-SNP to coordinate member care across Medicaid and Medicare (see Section 4.17.2 ICT Participant Roles and Responsibilities).

The Contractor will make ongoing efforts to coordinate with its aligned D-SNP to maximize integration of Medicare and Medicaid benefits and to achieve progressively higher levels of administrative alignment across all [MLTSS Program Name] MCE and D-SNP processes and systems. This will include alignment and integration of Indiana's SMAC requirements as well as the D-SNP model of care (MOC).

The Contractor shall develop clearly defined written protocols for how all relevant processes and systems will be coordinated with its aligned D-SNP. These written protocols will be reviewed annually by the state to ensure the closest alignment and integration possible.

The Contractor shall commit necessary staff and time resources for state-requested meetings with other [MLTSS Program Name] MCEs and aligned D-SNPs, other state agencies, stakeholders, and partners. These meetings would be focused on topics such as improving integration and alignment, assessing current performance of MCE and its aligned D-SNP, fostering program collaboration and innovation, and improving care coordination practices.

Within one year of [MLTSS Program Name] go-live, the Contractor shall implement a single unified member benefit card for all dually-eligible members enrolled in its aligned D-SNP. The single benefit card should provide the dually-eligible member with seamless access to all plan benefits regardless of payor source (Medicare or Medicaid).

A Contractor seeking D-SNP status for the first time shall be aware of the following general timeline for D-SNP implementation as it intersects with the [MLTSS Program Name] program.

CMS continues to develop this timeline therefore it is subject to change without notice to the State. CMS will provide more specific due dates as it gets closer to the time period in the general timeline described below. The Contractor is responsible for monitoring CMS information regarding

dates of submission for all necessary D-SNP related documentation. It is also responsible for understanding all state-specific requirements for the SMAC and any other D-SNP related materials.

2022, Nov	Contractor submits Notice of Intent to Apply (NOIA) to CMS for CY 2024
2023, Jan-Feb	Contractor submits the following to CMS: ▪ MA and Part D application ▪ Initial SNP application ▪ Model of Care (MOC)
2023, Apr 1	[MLTSS Program Name] contracts awarded
2023, May	CMS/NCQA issues MOC renewal terms of one, two, or three years
2023, Jun	Contractor submits the following to CMS for 2024: • Plan Benefit Package (PBP) • Completed Bid Pricing Tool (PBT) to CMS for the upcoming year Both D-SNP PBP and PBT should be consistent with all state SMAC requirements.
2023, July	Only successfully bidding [MLTSS Program Name] Contractors shall be permitted to submit executed State Medicaid Agency Contracts (SMACs) to CMS for CY 2024. The Indiana SMAC must include: • The minimum CMS requirements per *42 CFR 422.107*; • Any state-specific requirements incorporated in previous SMAC contracting cycles; and • All new state additions to better align CY2024 SMAC with [MLTSS Program Name] go-live.
2023, Sept	CMS issues SNP approval/denial notices
2024, Jan 1	[MLTSS Program Name] Contractor D-SNPs go-live
2024, April 1	[MLTSS Program Name] Contractor Medicaid MCE go-live

3.0 Covered Benefits and Services

The Contractor shall provide to its [MLTSS Program Name] members, one of two packages of service. The first, State Plan Medicaid, which includes nursing facility, home health and hospice care is available to all enrolled individuals. The second, State Plan Medicaid plus Home and Community Based Services (HCBS), is available to all who have been determined to meet the Level of Care set forth in 2.1 Eligibility Requirements. State Plan Medicaid services include at a minimum, all benefits and services deemed

“medically reasonable and necessary” and covered by the IHCP and included in the Indiana Administrative Code and under the Contract with the State. A covered service is considered medically necessary if it meets the definition as set forth in 405 IAC 5-2-17. HCBS services have a separate and distinct definition of medically necessary as described in Section 3.9.

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

- On the basis of criteria applied under the State Plan, such as medical necessity; or
- For the purpose of utilization control, provided the services furnished are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished;

3.1 Covered Benefits and Services

Exhibit 3 of the Contract provides a general description of the [MLTSS Program Name] benefit packages and the services and benefits that are available.

3.2 Self-referral Services

In accordance with state and federal requirements, the [MLTSS Program Name] program includes some benefits and services that are available to members on a self-referral basis. These self-referral services shall not require a referral from the member’s PMP or authorization from the Contractor.

The Contractor shall include self-referral providers in its contracted network. The Contractor and its PMPs may direct members to seek the services of the self-referral providers contracted in the Contractor’s network. The Contractor cannot require that the members receive such services from network providers, unless otherwise noted.

[MLTSS Program Name] members may self-refer to any IHCP provider qualified to provide the service(s). When [MLTSS Program Name] members choose to receive self-referral services from IHCP-enrolled self-referral providers who do not have contractual relationships with the Contractor, the Contractor is responsible for payment to these providers up to the applicable benefit limits and at 98% of Indiana Medicaid FFS rates, except for situations described under Section 2.8 of this contract.

Members may not self-refer to a provider who is not enrolled in IHCP.

The following services are considered self-referral services. The Indiana Administrative Code 405 IAC 5 [MLTSS Program Name] and provides further detail regarding these benefits.

- Chiropractic services may be provided by a licensed chiropractor, enrolled as an Indiana Medicaid provider, when rendered within the scope of the practice of chiropractic as defined in IC 25-10-1-1 and 846 IAC 1-1 who has entered into a provider agreement under IC 12-15-11.
- Eye care services, except surgical services may be provided by any provider licensed under IC 25-22.5 (Doctor of Medicine or doctor of osteopathy) or IC 25-24 (optometrist) who has entered into a provider agreement under IC 12-15-11.

- Routine Dental services may be provided by any in-network licensed dental provider who has entered into a provider agreement under IC 12-15-11.

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

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

- Family planning services under federal regulation 42 CFR 431.51(b)(2) require a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services also include sexually transmitted disease testing. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP provider qualified to provide the family planning service(s), including providers that are not in the Contractor's network. Members may not be restricted in choice of a family planning service provider, so long as the provider is an IHCP provider. The IHCP Provider Manual provides a complete and current list of family planning services.

- Emergency services are covered without the need for prior authorization or the existence of a Contractor contract with the emergency care provider. Emergency services shall be available twenty-four (24)-hours-a-day, seven (7)-days-a-week subject to the "prudent layperson" standard of an emergency medical condition, as defined in 42 CFR 438.114, which relates to emergency and post-stabilization services, and IC 12-15-12. See Section 3.4 for more information.

- Urgent care services are covered for members on a self-referral basis. See Section 6.2.12 for specific urgent care network requirements.

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

- Diabetes self-management services are self-referral if rendered by a self-referral provider. See Section 3.2 for more.

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

    - Outpatient mental health clinics;
    - Community mental health centers;
    - Psychologists;
    - Licensed psychologists;
    - Health services providers in psychology (HSPPs);
    - Licensed social workers;
    - Licensed clinical social workers;
    - Psychiatric nurses;
    - Independent practice school psychologists;

- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center; and
- Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option).

3.3 Pharmacy

Prescription drugs including injections and infusions, certain over-the-counter drugs, and pharmacy supplements are benefits under the [MLTSS Program Name] to be covered by the Contractor. The Contractor agrees to abide by 42 CFR 438.3(s), the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) and P.L. 115-271, "SUPPORT" Act.

The Contractor shall support FSSA in promptly responding to public and legislative inquiries involving the design and management of the Contractor's pharmacy benefit. If the Contractor elects to subcontract with a PBM, the Contractor shall ensure compliance with all subcontracting requirements outlined in Section 2.9, including but not limited to conducting regular audits and monitoring of the subcontractor's data and performance, as well as requiring their PBM to conduct regular audits of their pharmacy provider networks.

Pursuant to 405 IAC 1-14.6-10, all over-the-counter, legend and non-legend drugs shall not be included in the established rate and will be reimbursed separately by the pharmacy benefit. Physician-administered drugs will also be covered under the pharmacy benefit. Covered drugs may be subject to utilization management that is no stricter than Fee for Service in amount, duration and scope.

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

The Contractor shall provide a proposal which considers a common or "unified" preferred drug list (PDL) for the pharmacy benefit. Unification of the PDL would include prior authorization (PA), step edit and utilization edit criteria.

The Contractor shall, at the direction of the Secretary, implement specified fee-for-service PDL and/or prior authorization, if unified PDL is not implemented. If directed as such by FSSA, the Contractor shall discontinue use of a commercial discount and commercial rebate agreements with pharmaceutical manufacturers for IHCP member pharmacy benefits or consolidate the pharmacy benefit under the FFS program.

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

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

In the first year of the program, the Contractor shall provide for one hundred and twenty (120) days of continuity of care for all pre-existing drug regimens for new members. The Contractor shall provide for ninety (90) days of continuity of care for all pre-existing drug regimens for all new members after the first year of the program. This will allow time for the PBM to work with the prescribing provider to negotiate future drug regimens.

The contractor shall always ensure that, during the term of this contract, its pharmacy benefit fully complies with applicable provisions of IC 12-15-35 and IC 12-15-35.5.

3.3.1 Drug Rebates

The Contractor shall ensure compliance with the requirements under Section 1927 of the Social Security Act. In accordance with the Affordable Care Act, manufacturers that participate in the Medicaid drug rebate program are required to pay rebates for drugs dispensed to individuals enrolled with a Medicaid Managed Care Organization. To facilitate collection of these rebates, FSSA shall include utilization data of [MLTSS Program Name] MCEs when requesting quarterly rebates from manufacturers as well as in quarterly utilization reports to the Centers for Medicare and Medicaid Services (CMS). Thus, the Contractor shall timely submit their pharmacy encounter data completely and accurately to the State, in a manner required by the State. The Contractor shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of paid amounts. The State intends to use and share the Contractor paid amount information on the State's pharmacy claim extracts for rebate purposes. Requirements for pharmacy encounter claims are outlined in Section 9.8.

The report will include information on the total number of units of each dosage form, strength and package size by National Drug Code (NDC) of each covered outpatient drug dispensed to Contractor members and such other data that the Secretary of CMS determines necessary for the State to access rebates. This reporting shall include physician-administered drugs. For more information on reporting, please refer to Section 10.0, as well as the [MLTSS Program Name] MCE Reporting Manual.

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

Additionally, the Contractor shall assist OMPP or the State's PBM Contractor in resolving drug rebate disputes with the manufacturer. The Contractor will work with FSSA or its vendor to require resubmission and correction of claims from providers pursuant to billing errors or manufacturer rebate disputes in a timeframe designated by FSSA.

3.3.2 Preferred Drug List and Formulary Requirements

The Contractor shall maintain a preferred drug list (PDL) for the Contractor's [MLTSS Program Name] packages.

The [MLTSS Program Name] PDL shall support the coverage and non-coverage requirements for legend and non-legend drugs by Indiana Medicaid. More information can be found in 405 IAC 5-24-3, 405 IAC 5-24-4, 405 IAC 5-24-5 and 407 IAC 3-10-1. In accordance with CMS-2390-F, the Contractor shall demonstrate prescription drug coverage consistent with the amount, duration, and scope of the fee-for-service program. The Contractor shall engage with the State process to develop universal medically necessary prior authorization criteria for IHCP. The Contractor shall implement the universal IHCP criteria into their program and may not utilize more restrictive criteria.

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

At least thirty-five (35) days before the intended implementation date of the PDL and formulary, the Contractor shall submit its proposed PDL and formulary to OMPP. The OMPP shall submit the PDL and formulary to the Drug Utilization Review (DUR) Board for review and recommendation. The Contractor shall be accessible to the DUR Board to respond to any

questions regarding the PDL and formulary. The DUR Board will provide a recommendation regarding approval of the PDL and formulary in accordance with the terms of IC 12-15-35-46. OMPP will approve, disapprove or modify the PDL and/or formulary based on the DUR Board's recommendation. The Contractor shall comply with the decision within sixty (60) days after receiving notice of the decision.

The Contractor shall utilize a Pharmacy and Therapeutics Committee which shall meet regularly to make recommendations for changes to the PDL and/or formulary. In accordance with IC 12-15-35-47, prior to removing one (1) or more drugs from the PDL and/or formulary or otherwise placing new PA criteria on one (1) or more drugs, the Contractor shall submit the proposed change to the OMPP which shall forward the proposal to the DUR Board. Such changes shall be submitted at least thirty-five (35) calendar days in advance of the proposed change. The Contractor shall also meet with OMPP staff, as directed by OMPP, to answer questions about the clinical rationale for the proposed change. The DUR Board will provide a recommendation regarding approval of the proposed change to the PDL and/or formulary in accordance with the terms of IC 12-15-35-47. OMPP will approve, disapprove or modify the PDL and/or formulary based on the DUR Board's recommendation. The Contractor is not required to seek approval from the State in order to add a drug to the PDL or formulary; however, the Contractor shall notify the OMPP of any addition to the PDL and/or formulary within thirty (30) days after making the addition.

The PDL and formulary shall be made readily available to providers in the Contractor's network and to members. The PDL and formulary shall be updated to reflect all changes in the status of a drug or addition of new drugs. The Contractor shall also support e-Prescribing technologies to communicate the PDL and formulary to prescribers through electronic medical records (EMRs) and e-Prescribing applications. See Section 3.3.5 for additional requirements on e-Prescribing. Consistent with the requirements of Section 6.11, the Contractor shall develop provider education and outreach aimed at educating providers about the [MLTSS Program Name] PDL and formulary as well as the utilization of e-Prescribing technologies to ensure appropriate prescribing for members based on the member's benefit plan.

3.3.3 DUR Board Reporting Requirements

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

1. An analysis of the single source drugs requiring prior authorization in comparison to other contractor's prescription drug programs in the [MLTSS Program Name] program.
2. A determination and analysis of the number and the type of drugs subject to a restriction.
3. A review of the rationale for the prior authorization of a drug and a restriction on a drug.
4. A review of the number of requests a Contractor received for prior authorization, including the number of times prior authorization was approved and disapproved.
5. A review of patient and provider satisfaction survey reports and pharmacy-related grievance data for a twelve (12) month period.

The Contractor shall provide OMPP with the information necessary for the DUR Board to conduct this review in the timeframe and format specified by OMPP. In addition to the DUR Board approval, the Contractor shall also seek the advice of the Mental Health Medicaid Quality Advisory Committee, as required in IC 12-15-35.5, prior to implementing a restriction on a mental health drug described in IC 12-15-35.5-3(b).

The Contractor shall supply, on a quarterly basis, a report to the Office and the DUR Board of the number of member days of missed therapy due to prior authorization. The format of this report will be agreed upon by the Contractor, the Office and the DUR Board. In addition, the Contractor shall comply with any additional reporting requests required for submission to the DUR Board. Please refer to the [MLTSS Program Name] MCE Reporting Manual for more information on pharmacy reporting requirements.

The Contractor shall provide the DUR Board statistics at the DUR Board's monthly meetings. These statistics may include information on drug utilization or prior authorization reports as requested by the State.

3.3.4 Dispensing and Monitoring Requirements

The Contractor shall administer pharmacy benefits in accordance with all applicable state and federal laws and regulations. The Contractor shall comply with the requirements of IC 12-15-35.5-3 in establishing prescribing limits to mental health drugs. For any drugs which require prior authorization, the Contractor shall provide a response by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization. Additionally, the Contractor shall provide for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation as required under 42 U.S.C 1396r-8(d)(5)(B). The Contractor shall employ an automated system for approval of a seventy-two (72) hour emergency supply of a restricted drug. The automated system shall allow the pharmacist to dispense the seventy-two (72) hour supply and then follow-up with the Contractor or provider the next business day.

The Contractor, implementing a unified PDL, shall implement the prior authorizations approved for all plans, by the DUR Board. The Contractor shall participate in the development and recommendation of prior authorization criteria brought before the DUR Board. If it elects to utilize its own prior authorization process, the Contractor may require prior authorization requirements, such as general member information, a justification of need for drug related to the medical needs of the member and a planned course of treatment, if applicable, as related to the number drug provided and duration of treatment. The Contractor will be required to have a process in place to allow drugs that are medically necessary but not included on the formulary to be accessed by members. The Contractor will be required to accept prior authorization requests via telephone, fax, web-based system, or in writing. To conform to 42 CFR 437-438.3(s) and the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F), once universal medically necessary prior authorization criteria for access to a prescription drug is developed, the Contractor's criteria must be consistent with the amount, duration and scope of that criteria and may not be more stringent.

The Contractor shall provide online and real-time rules-based point-of-sale (POS) claims processing for pharmacy benefits. The Contractor shall maintain prospective drug utilization review edits and apply these edits at the POS. Independently developed and implemented PA criteria will be displayed, in a common format, alongside fee for service and other Contractor criteria.

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

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

2. The MCE shall regularly report findings on audits performed and outcomes completed by the MCE on its PBM

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

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

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

3.3.5 E-Prescribing

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

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

The Contractor agrees to work with OMPP and the fee for service PBM to transition the pharmacy benefit back to the FFS PBM if OMPP decides to implement the FFS pharmacy benefit for [MLTSS Program Name] members.

3.3.6 Carve-Out of Select Drugs

Exhibit 3 of this Contract contains the list of drugs and agents excluded from the Contractor's capitation rate. These are referred to as "carved out" drugs. The State's fiscal agent pays claims for carved-out drugs on a fee-for-service basis for the Contractor's members. While these drugs are not the financial responsibility of the Contractor, the Contractor shall ensure coordination of all Medicaid covered drugs and implement strategies to prevent duplication and fragmentation of care across the healthcare delivery system.

3.3.7 SUPPORT Act Compliance

In accordance with the federal Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, the Contractor shall implement and maintain the following processes and standards:

1. Safety edits and claims review automated process for the State-approved maximum daily morphine limitation
2. Safety edits and claims review automated process for the State-approved maximum daily morphine equivalent for treatment of chronic pain
3. Claims review automated process that monitors when a client is concurrently prescribed opioids and benzodiazepines, or is concurrently prescribed opioids and antipsychotics
4. Process that identifies potential fraud or abuse of controlled substances by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies

3.3.8 Medicare Part D

The Medicare Modernization Act of 2003 (MMA) created the Medicare Part D prescription drug benefit for individuals enrolled in Medicare Part A and Medicare Part B coverages. Medicare Part D drug benefit plans cover prescription drugs as approved by the Centers for Medicare and Medicaid Services (CMS). For full benefit dual eligible members, Indiana Medicaid covers medically necessary, federally and state reimbursable prescription drugs that are excluded from coverage by CMS under Medicare Part D benefit plans. Contractors' coverage of CMS Medicare Part D excluded drugs, when ordered by a Primary Care Physician, attending physician, dentist or other authorized prescribing clinician and dispensed by a pharmacist or a pharmacy intern acting under the direct supervision of a pharmacist in accordance with Indiana Board of Pharmacy Rules and Regulations, are covered if the drug is medically necessary and federally reimbursable. Prescription drugs and therapeutic classes that are covered by a Medicare Part D drug benefit plan, but are not specifically listed in the Medicare Part D Drug List, are considered to be covered by the Medicare Part D drug benefit plan, and are not covered by Indiana Medicaid. Drugs eligible for coverage under Medicare Part D will not be covered under Medicaid if the member refuses Part D coverage.

3.3.9 Long Term Care and Pharmacy

All over-the-counter, legend, and non-legend drugs, including physician-administered drugs are not considered allowable costs and should not be included in the per diem rate. All drugs must be reimbursable through the pharmacy benefit but may be subject to prior authorization and safety edits that are no more restrictive than Fee-for-Service.

3.3.10 Pharmacy Benefit Manager Contracting

The Contractor shall assure proper and complete PBM agent training.

If the Contractor enters into a contract or agreement with a Pharmacy Benefit Manager (PBM) for the provision and administration of pharmacy services, the contract or agreement shall be developed as a pass-through pricing model as defined below:

1. All monies related to services provided for the Contractor are passed through to the Contractor, including but not limited to: dispensing fees and ingredient costs paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, rebates (including manufacturer fees and administration fees for rebating), inflationary payments, and supplemental or commercial rebates;

2. All payment streams, including any financial benefits such as rebates, discounts, credits, clawbacks, fees, grants, reimbursements, or other payments that the PBM receives related to services provided for the Contractor are fully disclosed to the Contractor, and provided to the State upon request, and;

3. The PBM is paid an administrative fee which covers the cost of providing the PBM services as described in the PBM contract or agreement as well as margin.

The payment model for the PBM's administrative fee shall be made available to the State. The State reserves the right to request pharmacy claims-level payment information at any time. If concerns are identified, the State reserves the right to request any changes be made to the payment model.

3.4 Emergency Services

The Contractor shall cover emergency services without the need for prior authorization or the existence of a contract with the emergency care provider. Services for treatment of an emergency medical condition, as defined in 42 CFR 438.114, which relates to emergency and post-stabilization services, and IC 12-15-12 (i.e., subject to the "prudent layperson" standard), shall be available twenty-four (24)-hours-a-day, seven (7)-days-a-week.

The Contractor shall contract with urgent care clinics. Urgent care clinics shall be made available no less then eleven (11) hours each day Monday through Friday and no less than five (5) hours each day on the weekend.

The Contractor shall cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR 489.24, which sets special responsibilities for hospitals in emergency cases, provided to a member who presents to an emergency department with an emergency medical condition. The Contractor shall also comply with all applicable emergency services requirements specified in IC 12-15-12. The Contractor shall reimburse out-of-network emergency providers at one hundred percent (100%) of the Medicaid rate, unless other payment arrangements are made. The Contractor is required to reimburse for the medical screening examination and facility fee for the screening but is not required to reimburse providers for services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition, unless the Contractor authorized this treatment. The Contractor shall pay the contracted or fee schedule rate for an observation stay, regardless of whether a related emergency department visit was determined emergent.

In accordance with 42 CFR 438.114, which relates to emergency and post-stabilization services, the Contractor may not:

1. Limit what constitutes an emergency on the basis of lists of diagnoses or symptoms;

2. Deny payment for treatment obtained when a member had an emergency medical condition, even if the outcomes, in the absence of immediate medical attention, would not have been those specified in the definition of emergency medical condition;

3. Deny or pay less than the allowed amount for the CPT code on the claim without offering the provider the opportunity for a medical record review. The Contractor shall conduct a prudent layperson review to determine whether an emergency medical condition exists; the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field;

4. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent's failure to notify the Contractor of the member's screening and treatment within ten (10) calendar days of the presentation for Emergency Service;

5. Refuse to cover services if a representative of the Contractor instructed the member to seek Emergency Services;

6. Hold the member liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition; nor

7. Prohibit the treating provider from determining when the member is sufficiently stabilized for transfer or discharge. The determination of the treating provider is binding for coverage and payment purposes and the Contractor may not challenge the determination.

The Contractor shall comply with policies and procedures set forth the IHCP Provider Bulletin regarding Emergency Room Services Coverage dated May 21, 2009 (BT200913) and January 30, 2020 (BT202009), and any updates thereto.

If the Contractor chooses to use a list of diagnosis codes to initially determine whether a service may be an emergency, the MCE must, at a minimum, use the State's Emergency Department Autopay List, accessible from the Code Sets page at in.gov/Medicaid/providers. The Contractor must check at a minimum the diagnosis codes in fields 67 and 67A-E on the UB04 and 21A-F on the CMS 1500 against the emergency department autopay list.

The Contractor's provider remittance advices for claims reduced to a screening fee shall include a notice alerting providers:

- Where to submit medical records for prudent layperson review.
- That the provider has one hundred and twenty (120) days to submit medical records for prudent layperson review.
- The location where the provider can find any additional requirements for the submission of medical records for prudent layperson review.

If a prudent layperson review determines the service was not an emergency, the Contractor shall reimburse for physician services billed on a CMS-1500 claim, in accordance with the IHCP Provider Bulletin. The Contractor shall reimburse for facility charges billed on a UB-04 in accordance with the IHCP Provider Bulletin, if a prudent layperson review determines the service was not an emergency.

The Contractor shall have the following mechanisms in place to facilitate payment for emergency services and manage emergency room utilization:

- A mechanism in place for a plan provider or Contractor representative to respond within one (1) hour to all emergency room providers twenty-four (24) hours-a-day, seven (7) days-a-week. The Contractor will be financially responsible for the post-stabilization services if the Contractor fails to respond to a call from an emergency room provider within one hour.

- A mechanism to track the emergency services notification to the Contractor (by the emergency room provider, hospital, fiscal agent or member's PMP) of a member's presentation for emergency services.

- A mechanism to document a member's PMP's referral to the emergency room and pay claims accordingly.

- A mechanism in place to document a member's referral to the emergency room by the Contractor's 24-Hour Nurse Call Line and pay claims resulting from such referral as emergent.

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

- A mechanism and process to accept medical records for a prudent layperson review with an initial claim and after a claim has processed. The Contractor must at a minimum allow a provider to submit medical records for a prudent layperson review within one hundred and twenty (120) days of a claim's adjudication.

3.4.1 Post-Stabilization Services

In accordance with 42 CFR 438.114(e), 42 CFR 422.113(c), and IC 12-15-12-17, the Contractor must cover post-stabilization services. Post-stabilization services are covered services related to an Emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, to improve or resolve the member's condition. The Contractor is financially responsible for:

- Services obtained within or outside the network that are pre-approved by a plan provider or Contractor representative;
- Post-stabilization services that are not pre-approved but administered to a member to maintain the stabilized condition within one (1) hour of the request to the Contractor for pre-approval of further post-stabilization services;
- Reimbursement for post-stabilization services when (i) the Contractor does not respond within one (1) hour to a request for pre-approval, (ii) the Contractor cannot be contacted or (iii) the Contractor and treating physician cannot reach an agreement concerning the members' care and a Contractor provider is not available for consultation. In this situation, the Contractor must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with the care of the patient until a plan provider is reached or one of the following conditions is met:

    - A plan provider with privileges at the treating hospital assumes responsibility for the member's care;
    - A plan provider assumes responsibility for the member's care through transfer;
    - A Contractor representative and the treating provider reach an agreement concerning the member's care; or
    - The member is discharged.

3.5 Smoking Cessation and Tobacco Dependence Treatment

The Contractor must cover, at minimum, Smoking Cessation and Tobacco Dependence Treatment as set forth in 405 IAC 5-37. Drug coverage and criteria shall be consistent with the fee-for-service program (refer to 3.4 Drug Coverage), including counseling and all covered outpatient drugs indicated for Smoking Cessation and Tobacco Dependence Treatment. Providers may prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment. The Contractor shall provide each member identified as using tobacco or tobacco related products, information regarding the availability of tobacco cessation services provided through the Indiana Quitline. The Contractor shall create and implement a physician incentive program specific to tobacco dependence counseling. Contractor shall utilize a promotional strategy for tobacco cessation medications approved by FSSA to increase appropriate use of member drug benefits.

3.6 Behavioral Health

Behavioral health services, with the exception of Medicaid Rehabilitation Option (MRO) and 1915(i) services as described in Section 3.20 Carved-out Services, are a covered benefit under the [MLTSS Program Name] program. The Contractor shall be responsible for managing and reimbursing all such services in accordance with the requirements in this section. In furnishing behavioral health benefits, including any applicable utilization restrictions, the Contractor shall comply with the Mental Health Parity and Additions Equity Act (MHPAEA). This includes, but is not limited to:

1. Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits.

2. Ensuring compliance with MHPAEA for any benefits offered by the Contractor to members beyond those otherwise specified in this Scope of Work.

3. Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential members or contracting provider upon request.

4. Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members.

5. Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

The Contractor shall assure that behavioral health services are integrated, regardless if the member resides in a facility or the community, with physical care services, and that behavioral health services are provided as part of the treatment continuum of care. The Contractor shall develop protocols to:

1. Provide care that addresses the needs of members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health;

2. Provide a written plan and evidence of ongoing, increased communication between the PMP, the Contractor and the behavioral health care provider; and

3. Coordinate management of utilization of behavioral health care services with MRO and 1915(i) services and services for physical health.

4. Ensure information is included in the Member Handbook and other materials to members and providers regarding how to access covered behavioral health services. Materials shall include information about behavioral health conditions that may be treated by a primary care provider (PCP) within their scope of practice.

3.6.1 Behavioral Health Care Services

The Contractor shall provide all medically necessary community-based, partial hospital and inpatient hospital behavioral health services as identified in Contract Exhibits 2 and 3. Contractors shall pay CMHCs at no less than the Indiana Medicaid FFS rate for any covered non-MRO service that the CMHC provides to members.

The Contractor shall provide behavioral health services through hospitals, offices, clinics, in homes, and other locations, as permitted under state and federal law. A full continuum of services, including crisis services, as indicated by the behavioral health care needs of members,

shall be available to members, including partial hospitalization services as described in 405 IAC 5-20-8.

The Contractor shall provide medically necessary covered court ordered behavioral health services to its members pursuant to court order(s). The contractor shall furnish these services in the same manner as services furnished to other members.

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

The Contractor must allow members to self-refer to any behavioral health care provider in the Contractor's network without a referral from the PMP. Members may also self-refer to any IHCP-enrolled psychiatrist. Refer to Section 3.2 for more information on self-referral.

3.6.2 Behavioral Health Provider Network

FSSA requires Contractors to develop a sufficient network of behavioral health providers to deliver the full range of behavioral health services. The network shall include psychiatrists, psychologists, clinical social workers and other licensed behavioral health care providers. In addition, Contractors shall provide inpatient care for a full continuum of mental health and substance use disorder diagnoses. See Section 6.2.5 for behavioral health network requirements. All services covered under the clinic option shall be delivered by licensed providers and qualified behavioral health professionals working under a licensed behavioral health provider as defined in 440 IAC 11-1-14.

The Contractor shall train its providers in identifying and treating members with behavioral health disorders and shall train PMPs and specialists on when and how to refer members for behavioral health treatment. The Contractor shall ensure use of standardized validated screening instruments for all adults related to behavioral health needs. The Contractor shall also train providers in screening and treating individuals who have co-existing mental health and substance use disorders. The Contractor is responsible for ensuring that its behavioral health network providers are trained about and are aware of the cultural diversity of its member population and are competent in respectfully and effectively interacting with individuals with varying cultural, racial, ethnic, and linguistic differences. The Contractor shall provide to OMPP its written training plan, which shall include dates, methods (e.g., seminar, web conference, etc.) and subject matter for training on integration and cultural competency as specified in Section 6.1.2 Access to Culturally and Linguistically Competent Providers and in line with the Contractor's Health Equity and Cultural Competency Plan as specified in Section 5.16.

Members shall be able to receive timely access to medically necessary behavioral health services. The network shall meet the access requirements specified in Section 6.2.5.

3.6.3 Care Coordination and Service Coordination for Members Receiving Behavioral Health Services

The Contractor shall employ or contract with ca care coordinators and service coordinators with training, expertise and experience in providing services to older adults receiving behavioral health services. These care coordinators and service coordinators shall serve as the member's care coordinator and/or service coordinator as described in Section 6.0. As is expected with any inpatient stay, the service coordinator or care coordinator shall contact members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization and schedule an outpatient in-person follow-up appointment to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge.

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

In addition, with the appropriate consent, the care coordinator and/or service coordinator shall notify the integrated care team when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance use disorder. This notification shall occur within five (5) calendar days of the hospital admission or emergency treatment.

3.6.4 Behavioral Health Coordination

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

The Contractor shall share member health data with physical and behavioral health providers and coordinate care for all members receiving both physical and behavioral health services, to the extent permitted by law and in accordance with the member's consent, when required. The Contractor shall contractually mandate that its behavioral health care network providers notify the Contractor within five (5) calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications, and other pertinent information. Disclosure of mental health records by the provider to the Contractor and to the member's physician is permissible under the Health Insurance Portability and Accountability Act (HIPAA) and state law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance use disorder records. The Contractor shall contractually require every network provider, including behavioral health providers, to ask and encourage members to sign a consent that permits release of substance use disorder treatment information to the Contractor and to the PMP or behavioral health provider, if applicable.

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

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

a. Primary and secondary diagnoses;
b. Findings from assessments;
c. Medication prescribed;
d. Psychotherapy prescribed; and
e. Other relevant information.

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

The Contractor shall develop additional mechanisms for facilitating communication across the member's integrated care team to ensure the provision of integrated member care. Incentive programs, case managers, behavioral health profiles, etc. are potential mechanisms to ensure care coordination and the reciprocal exchange of health information between physical and behavioral health providers. The Contractor shall evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes.

3.6.5 Behavioral Health Continuity of Care

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

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

3.6.6 Institution for Mental Disease (IMD)

Pending CMS approval, FSSA reserves the right to alter the coverage and length of stay restrictions in this section. The Contractor will cover short term stays in an Institution for Mental Diseases (IMD) for serious mental illness (SMI) and substance use disorder (SUD) under the State's §1115 SMI and SUD demonstration authorities. IHCP will follow federal guidance in accordance with 42 CFR 435.1010 as well as any additional criteria established by the State's §1115 waivers used to distinguish qualified IMD providers.

The Contractor will cover short term inpatient stays for serious mental illness (SMI) in a qualified Institution for Mental Disease (IMD) for members aged twenty-one (21) to sixty-four (64) and is required to maintain an average length of stay not to exceed thirty (30) days for all IMD stays for SMI. A maximum of sixty (60) days can be approved, if medically necessary, for short term IMD stays for SMI.

The Contractor will cover short term inpatient stays for substance use disorder (SUD) in a qualified Institution for Mental Diseases (IMD) for members aged twenty-one (21) to sixty-four (64) for up to fifteen (15) days in a calendar month as medically necessary for individuals with substance use disorder. If a member's IMD stay exceeds fifteen (15) days in a calendar month and the member is awaiting placement in a state operated facility (SOF) for treatment, the member will be disenrolled from the plan and enrolled in fee for service. For stays exceeding fifteen (15) days in a calendar month in which the member is not awaiting placement in a SOF, the member will remain enrolled with the Contractor and the state shall recover the entire monthly capitation payment for the member.

The Contractor will cover short term residential stays for substance use disorder (SUD) in a qualified Institution for Mental Diseases (IMD) for members aged twenty-one (21) to sixty-four

(64) and is required to maintain an average length of stay not to exceed thirty (30) days for all residential IMD stays for SUD.

The Contractor shall actively track and coordinate the care of members receiving care in an IMD. Anticipating and planning for a member's successful discharge should begin immediately upon a member's entry into an IMD.

Lists of qualified IMD providers under both §1115 waivers will be provided to the Contractor. The Contractor may not require or create incentives for the member to receive services in an IMD versus a setting covered under the State Plan.

In accordance with 42 CFR 435.1010, an IMD is generally defined as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases." This may include a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services. The Contractor will be responsible for reviewing and understanding all specific State criteria to distinguish qualifying IMDs under both SMI and SUD §1115 demonstrations as well as all related State guidance.

The Contractor must submit data related to IMD stays as outlined in the MCE Reporting Manual.

The proposed services and settings will be reimbursable and subject to the requirements contained in 42 CFR part 438.

3.7 Prevention and Wellness

3.7.1 Prevention and Wellness Plan

Prevention and wellness shall be part of the normal course of communications with members, and the development of the member's care plan. The Contractor shall inform all members of contributions they can make to the maintenance of their own health and the appropriate use of LTSS and health care services.

The activities and materials used in the prevention and wellness activities shall be accessible by the State and the Centers for Medicare & Medicaid Services (CMS). The Contractor's plan for implementing the prevention and wellness program must be approved by the State. At any time, the State determines there has been a significant change in the Contractor's capacity to offer prevention and wellness services or in the Contractor's projected membership, the State may require the Contractor to submit documentation to demonstrate its capacity to provide prevention and wellness services.

FSSA defines a significant change as a modification that occurs to an Indiana Medicaid program goal, objective, or priority; other than modifications done for clarity. This is inclusive not only to the Medicaid program's structure, goals or objectives but also includes changes resulting from legislative or other regulatory authority; unanticipated changes in health plan performance; achievement of quality goals; and/or changes based on stakeholder input and feedback.

3.7.2 Prevention and Wellness Program

The Contractor's prevention and wellness program shall include the following components:

- Program Coordination
  Designated staff are responsible for the coordination and delivery of services in the program.

- Practice Guidelines
  Practice guidelines are guidelines that are developed in consultation with contracting professionals to assist them to apply the current best evidence in making decisions about the care of individual members. The Contractor will review and update practice guidelines periodically, as appropriate.

The Contractor shall use practice guidelines for prevention and wellness services that include member education, motivation and counseling about long-term care and health care related services. The Contractor must disseminate or make available the guidelines to providers for whom the guidelines apply and, upon request, to members, guardians, appointed health care representatives, and others as designated by the member.

Practice guidelines that are condition-specific and/or disease related shall include the following elements:

- Overview of condition/disease;
- Information related to anticipating, recognizing and responding to condition/disease related symptoms;
- Information related to best practice standards for prevention and management of condition/disease;
- Guidelines/process for interdisciplinary team to use regarding negotiating incorporation of condition/disease prevention and management plan with member into the care plan; and
- Plan for quality assurance monitoring of guideline effectiveness.

- Measurement
  The capacity to collect, analyze and report data necessary to measure the performance of the prevention and wellness program. The reports based on this data shall be communicated to providers and members.

- Program Resources
  Mechanisms for facilitating appropriate use of prevention and wellness services and educating members on health promotion.

- Disease Prevention
  Information and policies on the prevention and management of diseases which affect the populations served by the Contractor. This includes specific information for persons who have or who are at risk of developing health problems that are likely to benefit from preventive practices. Hypertension and diabetes are examples of such health problems.

- Independent Functioning
  Information and policies on maintaining and improving members' functional status, and the ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) more independently, for the populations served by the Contractor. This includes specific information for persons who have or who are at risk of impaired ability to function independently and are likely to benefit from preventive practices.

- Outreach Strategies
  Outreach strategies for identifying and reaching members who are least likely to receive adequate preventive services.

- Special Health Issues

The dissemination of information relevant to the membership including guardians, appointed health care representatives, and others as designated by the member; such as nutrition, loneliness and social isolation, injury prevention, informal caregiver health, alcohol and other drug abuse (AODA) prevention, reducing self-mutilation behaviors, physical activity, skin integrity, self-care training, and coping with dementia-related illnesses and cognitive decline.

- General Information
  The dissemination of information on how to obtain the services of the prevention and wellness program (e.g., resource center, public health department etc.), as well as additional information on, and promotion of, other available prevention services offered outside of the Contractor, such as special programs on oral health.
- Sensitivity to Population
  Long-term care and health care related educational materials produced by the Contractor shall be appropriate for its target population(s) and reflect sensitivity to the diverse cultures served.

3.8 State Plan Authority Long Term Services and Supports

3.8.1 Nursing Facility

The Contractor shall provide nursing facility services for members. The nursing facility must be licensed by the Indiana state department of health and enrolled with the IHCP. The contractor must contract with any willing nursing facility provider who meets the criteria of licensure and IHCP enrollment who is willing to accept the provisions of the MCE's contract. This any willing provider requirement will be in place for the first three (3) years of contract operations.

The Contractor must not cover Nursing Facility services in a facility located outside of the state of Indiana. The Contractor shall not reimburse for bed-hold days in a nursing facility as a member benefit unless the member is under the care of hospice. All members residing in a nursing facility are directed to talk with their MCE and individual provider regarding any type of "bed-hold" or leave-day policy that may exist in that facility. The Contractor must assure that a nursing facility makes members aware of the facility bed-hold policies and The Contractor must assure that a member cannot be charged for services the member does not request. The Contractor cannot require that a nursing facility hold beds. The Contractor must assure that the facility informs a resident in writing prior to a hospital transfer or departure for therapeutic leave that Medicaid does not pay for bed holds; the facility must also communicate its policies regarding bed-hold periods. The Contractor must assure that the nursing facility has a written policy under which a resident, whose hospital or therapeutic leave exceeds Medicaid coverage limitations, is readmitted to the facility upon the first Long-Term Care availability of a bed in a semiprivate room, if the resident requires nursing facility-level services and is eligible for Medicaid nursing facility services. Regardless of the length of leave, if the individual remains eligible for nursing facility level of care and Medicaid, the individual may choose to be readmitted to the facility to the first available bed or be provided with care in a home or community setting at the member's discretion.

Nursing Facility Admission: The Contractor will follow state policy found in the IHCP Long-Term Care Provider Reference Module for Level of Care (LOC) Level I and Level II and Pre-Admission Screening Resident Review (PASRR) requirements. Level of Care and PASSR determinations are the responsibility of an independent FSSA vendor with oversight from the State.

Level-of-Care Outcomes Possible outcomes for an LOC assessment include the following:
– Approved for short-term nursing facility stay (30, 60, 90, or 120 calendar days)
– Approved for long-term nursing facility stay (more than 120 days)

– Denied for nursing facility stay

Before the nursing facility can be reimbursed for the care provided, the nursing facility or other appropriate entity must request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State or independent vendor must then approve the PASRR request and designate the appropriate level of care in the MMIS. The Contractor must coordinate care for its members that are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR, as described in the IHCP Provider Manual. The Contractor is responsible for payment for up to sixty (60) days for the authorized care of its members placed in a long-term care facility while the level of care determination is pending.

The Contractor shall have a Transition Coordinator to assist members who lose nursing facility level of care or are ready for discharge from a nursing facility. The Contractor must assist the member and Nursing Facility in creating a successful discharge or transfer to another residential setting. The Contractor must continue payment to the nursing facility while a discharge is on-going. This does not apply to an individual who loses Medicaid eligibility.

3.8.2 Home Health

In accordance with the Code of Federal Regulations 42 CFR 440.70, the Indiana Health Coverage Programs (IHCP) defines “home health services” as services provided on a part-time and intermittent basis to Medicaid members of any age in the member’s place of residence. Members may receive home health services in any setting in which normal life activities take place other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is, or could be, made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to members who are homebound. Home health services are available to IHCP members of any age when services are medically necessary, ordered in writing by a physician, performed on a part-time and intermittent basis in accordance with a written plan of treatment. Home health services include skilled nursing, home health aide services, and skilled therapies such as physical therapy, occupational therapy, and speech-language pathology.

3.8.3 Hospice

Hospice care is a specialized form of interdisciplinary healthcare designed to alleviate the physical, emotional, social and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease. Hospice care also provides for the psychological, social, spiritual and other needs of the hospice program patient’s family before and after the patient’s death.

The Contractor shall provide Hospice care to members who meet the criteria established by the Office and documented in the IHCP Hospice Provider Module. This applies to hospice in all settings:

- Routine home hospice care
- Continuous home hospice care
- Inpatient respite hospice care
- General inpatient hospice care

The Contractor shall assure that all Hospice providers are first enrolled with the IHCP and meet the requirements including that a hospice provider is required to be Medicare-certified as a

hospice before enrolling in the hospice provider in their network. The IHCP further requires a hospice to be licensed by the Indiana Department of Health (IDOH) as a requisite to enrollment as a Medicaid hospice provider. As such, the IHCP expects hospice providers to comply with the Medicare hospice conditions of participation, under Code of Federal Regulations 42 CFR 418.

3.9 Home and Community Based Services (HCBS)

The Contractor shall determine through an individualized care planning process the HCBS services to provide to members who meet the HCBS Level of Care. The Contractor shall refer to IHCP manual for service definitions for services that shall be considered when developing a service plan. The full listing and details on HCBS covered are available in the State's waiver and relevant IHCP modules. Additional services may be added upon CMS approval of the IHCP manual.

HCBS delivered to a member must meet the standard of being HCBS Medically Necessary for the individual in order to be part of that member's care plan. HCBS Medically Necessary means that the service meets any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist a member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.
- Will provide the opportunity for a member receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

New services that will be added to the HCBS Waiver include Informal Caregiving Coaching and Behavior Management, Goal Engagement and Customized Living.

<u>Informal Caregiver Coaching and Behavior Management Support</u>
The purpose of Informal Caregiver Coaching and Behavior Management is to enable the stabilization and continued community tenure of a member by equipping the member's informal caregiver(s) with the necessary skills to manage the member's chronic medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia. This service allows informal caregivers who are not eligible to participate in Structured Family Caregiving (i.e.) to access support.

<u>Goal Engagement</u>
The Goal Engagement program is a set of highly individualized, person-centered services that use the strengths of the member to improve their safety and independence. Goal Engagement Program services engage members in identifying and addressing their goals related to increasing functional independence, improving safety, decreasing depression and improving motivation, including addressing barriers to achieve and maintain maximum functional independence in their daily lives. Members receive a structured set of home visits conducted by a multidisciplinary team consisting of an Occupational Therapist (OT), a Registered Nurse (RN), and a home repair specialist. The member and OT work together to identify areas of concern using a standardized assessment tool.

<u>Customized Living</u>
Customized Living provides a member customized package of regularly scheduled, health-related and supportive services provided to a participant who meets eligibility requirements for nursing facility level of care, and that provides direct, hands-on assistance to members in order to meet functional health and

social needs as determined by an assessment, in accordance with Department requirements and as outlined in the participant's service plan.

3.10 Participant-Directed Attendant Care Services (PDACS)

In addition to the traditional agency model, the Contractor shall educate members who are eligible for HCBS on the option and offer the opportunity to self-direct Attendant Care Services as an alternative option.

Members will utilize an Employer Authority model, in which the member employs their own attendant care provider, who can be a family member, a friend, a neighbor, or any other qualified attendant care worker as determined by FSSA. Should the State decide to offer budget authority to members participating in PDACS, the Contractor shall implement those processes and procedures within the timeframe prescribed by the State. Member participation in PDACS is voluntary. Members may elect to participate in PDACS at any time, without affecting their enrollment in [MLTSS Program Name]. The Service Coordinator shall assess member interest in PDACS. They shall provide the member with information regarding the philosophy of self-direction and the availability of PDACS.
The information provided to members must include:

- A clear explanation that participation in PDACS is voluntary;
- An overview of the supports and resources available to assist members to participate to the extent desired in PDACS; and
- An overview of member rights and responsibilities, as defined by FSSA, including actions that may result in removal of participation in the PDACS, and the member's right to participate in the grievance process.

The Service Coordinator shall provide the member with a self-assessment instrument developed by the State. The self-assessment instrument shall be completed by the member with assistance from the member's Service Coordinator as appropriate. The Service Coordinator shall file the completed self-assessment in the member's file. If the member elects to participate in PDACS, the Service Coordinator shall complete the PDACS Enrollment Checklist and secure the member's signature. If the Service Coordinator determines that a member requires assistance to participate in PDACS, the Service Coordinator shall inform and support the member in that their needs to designating a representative to manage participation in PDACS on their behalf. The designated representative will provide the information on behalf of the member discussed above.

Members are permitted to have a representative assist them in participating in PDACS.
In order to participate in PDACS with the assistance of a representative, one of the following must apply: (1) the member must have the ability to designate a person to serve as his/her representative or (2) the member has a legally appointed representative who may serve as the member's representative.
A representative will meet, at minimum the following requirements:

- Be at least 18 years of age,
- Have a personal relationship with the member and understand his/her support needs;
- Knows the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and
- Be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each worker. Minimum weekly visits are necessary but depending on the needs of the member daily visits may be a necessity This frequency can be determined through the person-centered service planning process.

A member's representative will not receive payment for serving in this capacity and will not serve as the member's worker for PDACS. The Contractor will use a representative agreement developed by the State to document a member's choice of a representative for PDACS, the representative's contact information, and to confirm the individual's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein. The Contractor will notify the Financial Management

Services (FMS) within three (3) business days when it becomes aware of any changes to a representative's contact information.

The representative agreement will be signed by the member (or person authorized to sign on member's behalf) and the representative in the presence of the Service Coordinator. The Service Coordinator will include the representative agreement in the member's file and provide copies to the member and/or the member's representative and the FMS.

A member may change their representative at any time. The member will immediately notify their Service Coordinator and the FMS when they intend to change representatives. The Service Coordinator will verify that the new representative meets the qualifications as described above. A new representative agreement will be completed and signed, in the presence of the Service Coordinator, prior to the new representative assuming their respective responsibilities. The Service Coordinator will immediately notify the FMS in writing when a member changes their representative and provide a copy of the representative agreement. The Contractor will facilitate a seamless transition to the new representative, to minimize any interruptions or gaps in services. As part of the service plan development process, the Service Coordinator will educate the member about the importance of notifying the Service Coordinator prior to changing a representative.

The member's Service Coordinator shall provide the following support and assistance to members electing PDACS:

- Every ninety (90) days, the Service Coordinator must obtain a dated signature or documented acknowledgment from the member or member's representative on the Participant Directed 90 Day Review Checklist, to be provided by the State.
- Annually, the Service Coordinator must obtain a dated signature from the member or the member's representative on a form that states: "My Service Coordinator has explained the PDACS option to me. I understand that under this option I can choose to self-direct attendant care services." Affirm one of the two statements below: "I accept the offer of PDACS and my Service Coordinator is helping me explore that option." "I decline PDACS at this time but understand I can choose this option at any time in the future by asking my Service Coordinator."
- The Service Coordinator must maintain the signed forms as part of the member's file.
- Collaborate with the member during the service plan development to ensure that all issues related to the member's participation in PDACS are discussed and addressed, including:
    a. Potential areas for assistance and support to participate in PDACS to the extent the member desires;
    b. Identification of resources available to support members as needed, including a thorough investigation of natural supports, as well as identifying the members' preferences regarding how and by whom these supports are provided;
    c. Identification of potential health and safety issues related to PDACS and specific action plans to address these;
    d. For members with representatives, the identification of the need for their training in the area of identification of member preferences, and member self-advocacy training.
    e. Identification of how the member's participation in PDACS will be monitored to ensure member health, safety and welfare.

If the member has not designated a representative and the Service Coordinator determines that the member does not require a representative to assist the member in directing his/her care and services, the Service Coordinator shall forward to the FMS a referral initiating the member's participation in PDACS. The referral will include, at a minimum:

- The date of the referral;
- The member's name, address, telephone number, and Medical Assistance number;
- The name of the representative and telephone number (if applicable);
- The member's ID number;

- Member's [MLTSS Program Name] enrollment date; and
- Service Coordinator's name and contact information.
- The Service Coordinator will also forward to the FMS a copy of the written confirmation of the member's decision to participate in PDACS, the signed service plan, and the representative agreement, if applicable.

Referrals will be submitted electronically daily using the agreed upon data interface (either a standard electronic file transfer or the FMS's web portal technology or both) and process. Referrals will be submitted on a member-by-member basis.

The back-up plan for PDACS will include the names and telephone numbers of contacts (workers, agency staff, organizations, supports) for alternate care and services, the order in which each will be notified and the services to be provided by contacts. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the member electing consumer direction and/or his/her representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity. The Contractor will not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for attendant care services a member has elected to self-direct.

All persons and/or organizations noted in the backup plan for PDACS will be contacted by the member or representative to determine their willingness and availability to serve as backup contacts. For the initial backup plan, the FMS will confirm with these persons and/or organizations their willingness and availability to provide care when needed, document confirmation in the member's file and forward a copy of the documentation to the Contractor. The Service Coordinator will be responsible for updating and verifying the backup plan on an ongoing basis. The member's Service Coordinator will integrate the member's backup plan for PDACS (including any updates thereto) into the member's backup plan for services provided by other providers, as applicable, and the member's service plan. The Service Coordinator will review the backup plan developed by the member or their representative (as applicable) for PDACS to determine its adequacy to address the member's needs, and as part of ongoing service coordination activities to ensure that the member is receiving services as specified in the service plan, will monitor the back-up plan was implemented timely, when applicable, and the member's needs are being met. The Service Coordinator will collaborate with the FMS to assist the member or their representative (as applicable) in implementing the back-up plan for PDACS as needed, monitor to ensure that the back-up plan is implemented and effectively working to meet the member's needs, and immediately address any concerns with the back-up plan or the member's care. The Service Coordinator will assist the member or their representative (as applicable) in reviewing and updating the backup plan for PDACS at least annually and as frequently as necessary. As part of the annual review of the backup plan, the member or his/her representative and the Service Coordinator will confirm that each person specified in the backup plan continues to be willing and available to serve as backup workers to deliver needed care and to perform the tasks and functions needed by the member. Any updates to the backup plan for PDACS will be provided to the FMS. The Contractor and the FMS will each file a copy of the back-up plan for PDACS in the member's file.

For members electing self-direction of HCBS services, the Contractor shall allow eligible members to utilize the State's financial management services vendor(s). The Contractor shall treat the State's financial management services vendor(s) and all direct service workers employed under the financial management services vendor(s) as in-network providers. A member's chosen care providers shall enroll as IHCP providers under the State's financial management services vendor(s), unless those care providers are already IHCP enrolled through another means.

The FMS will provide training to the Contractor's Service Coordinators as outlined in Section 2.4.5 Staff Training and Qualifications. The FMS will fulfill, at a minimum, the following financial administration and supports brokerage functions for all members electing Participant-Directed Attendant Care Services:

- Within two (2) business days of receipt of the referral from the Service Coordinator, the FMS will assign a supports broker to the member, notify the Service Coordinator of the assignment and provide the name and contact information of the supports broker.
    a. The supports broker will be responsible for assisting the member with enrollment into PDACS and with the enrollment of new workers;
- Within five (5) days of receipt of the referral, the FMS will contact the member to inform the member of his/her assigned supports broker, provide contact information for the supports broker, and to begin the process of initiating PDACS.
- Notify the member's Service Coordinator immediately upon becoming aware of:
    a. Changes in the member's needs and/or circumstances which warrant a reassessment of needs, or
    b. Any additional risk associated with the member participating in PDACS that may need to be addressed in the member's service plan.
- Maintain a registry of individuals qualified and willing to serve as attendant care workers for the PDACS program;
- Conduct limited criminal background history checks on attendant care workers;
- Provide initial and ongoing training to workers on consumer direction and other relevant issues;
- Receive, review and process timesheets;
- Resolve discrepancies regarding timesheets;
- Develop and implement a process to support members or their representatives in ensuring that attendant care providers maintain in the member's home (or alternative location or format approved by the State) documentation of service delivery to support payments for services provided through consumer direction, and periodically monitor such documentation;
- Provide the member, the member's representative (as applicable) and the Service Coordinator with monthly reports on utilization and spending
- Withhold, file and pay applicable: federal, state and local income taxes; employment and unemployment taxes; and worker's compensation;
- File required labor reports;
- Issue W-2 wage statements annually;
- Pay workers for authorized services rendered within authorized timeframes;
- Facilitate resolution of any disputes regarding payment to workers for services rendered; and
- Notify the Contractor within no more than twenty-four (24) hours of identification of Unusual Occurrences.
- The FMS will also provide the following information and supports on an as-needed basis:
- Assist the member and/or representative in completing employer forms and paperwork; Assist the member and/or representative in developing job descriptions;
- Assist the member and/or representative in locating and recruiting workers;
- Assist the member and/or representative in interviewing workers (developing questions, evaluating responses);
- Assist the member and/or representative in developing (as part of the onboarding process for new workers) a schedule for the member's workers that comports with the schedule at which services are needed by the member as reflected in the member's service plan;
- Assist the member and/or representative in managing and monitoring payments to workers; and
- Assist the member/representative in identification and training of new workers, as needed.
- Explain requirements and processes, including timeframes, for claims submission and payment and coding requirements;
- Explain the FMS's role and responsibility in implementing the Contractor's fraud, waste, and abuse plan;
- Explain Contractor's program quality requirements; and
- The Contractor's member grievance and appeal processes.

- The Contractor or the FMS must provide the following training on PDACS to all members participating in the PDACS:
    a. Understanding the role of representatives in PDACS;
    b. Understanding the role of the Service Coordinator and the FMS;
    c. Selecting workers;
    d. Abuse and neglect prevention and reporting;
    e. Nondiscrimination prevention and reporting;
    f. Being an employer, evaluating worker performance and managing workers;
    g. Fraud, waste, and abuse prevention and reporting;
    h. Performing administrative tasks such as reviewing and approving timesheets;
    i. Application of electronic visit verification systems
    j. Scheduling workers and back-up planning; and
    k. Ensuring workers maintain daily communication notes for authorized services provided.

Ongoing training will be provided by the FMS to members and/or representatives upon request and/or if the Service Coordinator or FMS, through monitoring, determines that additional training is warranted. The Service Coordinator has primary responsibility for oversight and monitoring members' utilization and management of PDACS.

The Service Coordinator will have face-to-face contact with the member participating in PDACS at least every ninety (90) days. The Service Coordinator will review the person-centered service plan include self-direction with the member for continuing use of PDACS every ninety (90) days. The Contractor will monitor service utilization by members using PDACS. The Contractor will monitor implementation of the back-up plan by the member or his/her representative. The Contractor will monitor a member's participation in PDACS to determine, at a minimum, the success and the viability of the service delivery model for the member. The Contractor will note any patterns, such as frequent turnover of representatives or workers, habitual mismanagement of authorized services, failure to cooperate with the FMS and changing between PDACS and agency-delivered attendant care services which may warrant intervention by the Contractor.

If at any time an Unusual Occurrence is suspected, the member's Service Coordinator or the FMS will report the allegations using the web-based Incident Reporting system administered by the State. If the allegation concerns physical or sexual abuse and is in reference to a worker or representative, the FMS will contact the member/representative to determine if the member/representative wants to place the worker on unpaid leave until an investigation has been completed. If the representative is the subject of the allegation, the representative will not be allowed to decide whether to take leave, and such a decision will solely be up to the member. The member/representative may additionally decide to remove staff at their discretion. The FMS will notify the Contractor regarding this communication with the member/representative and the member or representative's decision. The Service Coordinator will work with the member to find a new representative and the FMS will work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, then the representative and/or worker will no longer be allowed to participate in PDACS in any capacity. If the investigation does not result in such placement, then the member may elect to retain the worker or representative.

A member may voluntarily withdraw from PDACS at any time. The member and/or representative will be advised to notify the Service Coordinator as soon as he/she determines that he/she is no longer interested in participating in PDACS. Upon receipt of a member's request to withdraw from PDACS, the Service Coordinator will conduct a face-to-face visit and update the member's service plan, as appropriate, to initiate the process to transition the member to agency-provided attendant care services.

The member shall be identified for involuntary termination from PDACS, if either the FMS or Service Coordinator identify any of the following:

- An immediate health and safety risk associated with participant-direction, such as, imminent risk of death or irreversible or serious bodily injury related to the provision of PDACS;

- Paid caregiver abuse
- Misuse of funds;
- Failure to follow PDACS policies and/or guidance;
- Providing false information and/or documentation;
- Member has been convicted of illegal activity.

A paid caregiver providing PDACS to a member shall be identified for involuntary termination from PDACS, if either the FMS or Service Coordinator identify any of the following:

- An immediate health and safety risk associated with participant-direction, such as, imminent risk of death or irreversible or serious bodily injury related to the provision of PDACS;
- Member abuse and/or neglect;
- Misuse of funds following notification and technical assistance from the FMS and/or the Service Coordinator;
- Failure to follow PDACS policies and/or guidance, following notification and technical assistance from the FMS and/or the Service Coordinator;
- Providing false information and/or documentation;
- Paid caregiver has been determined in violation of 455 IAC 2-15-2.

The Contractor will forward to FSSA any cases in which the Contractor plans to involuntarily terminate a member from PDACS. If FSSA approves the Contractor's request, the Contractor will notify the member which will activate the member's right to appeal the determination. Upon receipt of a member's request to withdraw from PDACS, the Service Coordinator will conduct a face-to-face visit and update the member's service plan, as appropriate, to initiate the process to transition the member to agency-provided attendant care services. The member will be advised of their right to appeal the determination of involuntary termination. PDACS shall continue during the appeal. Members or paid caregivers who have been involuntarily terminated may request to be reinstated to PDACS after twenty-four (24) months have elapsed. The Service Coordinator will work with the FMS to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to reinstatement. All members will be required to participate in PDACS programs prior to re-instatement in PDACS.

3.11 Informal Caregiver Support

3.11.1 Informal Caregiver Training, Education, and Resources

For members who are not determined to meet NFLOC and who have an informal caregiver, the member's Care Coordinator shall refer the member's identified, informal caregiver to resources, including training and education, appropriate and applicable to the member and caregiver's needs. The Contractor shall refer all Informal Caregivers, regardless of the member's NFLOC determination, to training such as how to assist/support the member with activities of daily living, changing bandages, administering medications and injections, transferring from bed to chair, precautions to prevent infectious diseases in the home and community. The Contractor shall provide education specific to the member's illness, condition, or disability as informed by the member's care/service plan. Education on the significance of an informal caregiver's role in the overall health and welfare of the member shall be provided. The Contractor shall provide, on at least an annual basis, and when otherwise appropriate, education on how to identify and report suspected abuse and neglect.

Additionally, non-waiver supports should be coordinated by the Contractor with the informal caregiver and may include providing directories and assistance in contacting community social supports, food banks, utility and housing assistance, legal services, financial services, insurance assistance, support groups, and respite services. The Contractor is encouraged to identify other community health resources and opportunities local to the member and their informal caregiver. The Contractor shall provide training, education, and resources in accessible formats to ensure access for the informal caregivers. Example formats include, but are not limited to, in-person meetings, telephonic and web platforms, written toolkits and guidebooks. In addition, the

Contractor shall observe the communication requirements in Section 5.4. Member Information, Education and Outreach.

For members who are determined to meet NFLOC and have an informal caregiver, the member's Service Coordinator shall conduct an informal caregiver assessment with the consent of the member. Based on the result of the informal caregiver assessment and the informal caregiver's preferences, the Contractor shall provide access to resources that would support and assist the informal caregiver in their role, including authorizing waiver services that directly impact caregivers, such as Structured Family Care, Informal Caregiver Coaching and Behavior Management, or Self-Directed Attendant Care. For informal caregivers who receive the Informal Caregiver Coaching and Behavior Management waiver service, the member's Service Coordinator shall provide the waiver service provider with the results of the informal caregiver assessment and a record of any referrals to training, education, or resources that the Contractor has already provided to the informal caregiver, to reduce assessment and/or service duplication.

The Service Coordinator shall work with the informal caregiver and Informal Caregiver Coach, as applicable (Section 3.11.2), on the creation of a crisis management/emergency plan to support unplanned events that could impact the member and environment. The plan will be reviewed and updated at the time of reassessment or as needed and provided to the Contractor and listed entities on the plan. Permissions from the member to share this information is necessary. The plan shall include but is not limited to the following:

- Health conditions.
- Advance Care Planning: advance directives, will planning, physician orders for life sustaining treatment (POST) form, etc.
- Medications and/or medication management/assistance to prevent medication errors, if part of the care/service plan.
- Fall prevention interventions, as necessary.
- Healthcare providers including contact information.
- Emergency contacts.
- Identification and contact information for back-up informal caregiver(s).
- Contact information for Informal Caregiver Coach and Contractor Care Team.
- Informal caregiver resources available within the caregiver's/member's community of choice.

3.11.2 Informal Caregiver Coaching

Pending CMS approval of the Informal Caregiver Coaching and Behavior Management waiver service, an Informal Caregiver Coach is a provider authorized to deliver the Informal Caregiver Coaching and Behavior Management waiver service within the Contractor's network who is assigned to an informal caregiver. The Contractor shall consider an Informal Caregiver Coach as a member of the Contractor's Care Coordination team, and the Contractor shall incorporate the Informal Caregiver Coach in care/service planning as applicable and with the consent of the member. The Informal Caregiver Coach shall be the Informal Caregiver's primary point of contact. Informal Caregiver Coaching and Behavior Management waiver services shall be delivered in-person, telephonically, and/or through HIPAA secure electronic communication platforms that enable an Informal Caregiver Coach and an informal caregiver to communicate efficiently and, in a manner, convenient to the informal caregiver. Provider agencies must capture any informal caregiver communications received through an electronic communication platform to facilitate the sharing of relevant information with the Contractor. An Informal Caregiver Coach engages with an informal caregiver on a periodic basis or upon request by the informal caregiver, to understand the evolving needs of the member and informal caregiver and deliver education, strategies and tools related to the support of the member's needs and the informal caregiver's self-care needs.

3.12 Housing

Safe, stable and affordable housing in the least restrictive community setting, is a critical component of a member's overall well-being and care. The Contractor shall have policies in place outlining the process to evaluate each member's housing needs as well as coordination of care processes to assist members in attaining and maintaining housing and supportive services.

In the event the Contractor identifies a member at risk of homelessness, the Contractor shall assist the member to obtain and maintain a home in the community and make every effort to assist members in navigating community housing and housing support resources.

Contractor and/or community housing assistance shall include but is not limited to: ensuring housing needs are evaluated as part of identifying independent living goals and service planning, housing search assistance, assistance and applying for housing and benefits, assistance with SSI eligibility processes, advocacy and negotiation with landlords and other tenants, moving assistance, eviction prevention, identification of supportive housing services, and incorporating social determinants of health into the person-centered planning process.

When applicable, the Contractor shall participate in local and statewide housing collaboratives, which may include local and state housing agencies such as the Indiana Housing & Community Development Authority, and social services organizations. The Contractor, in collaboration with FSSA, shall develop a strategy to strengthen networks with housing providers and develop access to affordable housing. This shall include collaborating with other managed care organizations, and other stakeholders to develop and implement strategies for the identification of resources to assist in placing members in affordable housing.

The Contractor shall have a Housing Coordinator dedicated to overseeing housing services and supports for the [MLTSS Program Name]. Additionally, Contractor care managers and service coordinators shall have training on housing needs assessment and resource identification for members including legal and financial resources.

3.13 Medical Equipment

The Contractor is responsible for coverage of Durable Medical Equipment (DME), Home Medical Equipment (HME) and Medical Supplies as detailed in both Indiana Administrative Code and the IHCP Provider Module for Durable and Home Medical Equipment and Supplies. Indiana Administrative Code 405 IAC 5-19-2 defines durable medical equipment (DME) as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a member in the absence of illness or injury. Indiana Code IC 25-26-21-2 defines home medical equipment (HME) as equipment that is prescribed by a healthcare provider; sustains, restores, or supplants a vital bodily function; and is technologically sophisticated and requires individualized adjustment or regular maintenance. HME does not include walkers, ambulatory aids, commodes, or any HME that the Indiana board of pharmacy specifies not to be regulated. For individuals receiving HCBS LTSS the Contractor shall be responsible for coverage of Specialized Medical Equipment & Supplies (SMES) as defined in the IHCP manual, currently under the Aged & Disabled waiver section. SMES assist the participant in maintaining their health, welfare and safety, and enable the participant to function with greater independence in the home.

The Contractor will, at a minimum, provide coverage for the procedure codes that the Indiana Health Coverage Programs (IHCP) covers for DME providers (specialty 250) and HME providers (specialty 251), see Durable and Home Medical Equipment and Supplies Codes, accessible from the Code Sets page at in.gov/Medicaid/providers.

The Contractor may require a physician order for all DME and HME.

The Contractor may require a Prior Authorization for DME, HME and medical supplies. PA criteria shall be consistent with IHCP criteria outlined in 405 IAC 5-19. The PA requirements in this document should be used as a guideline for determining procedures requiring PA, but the IAC and any subsequent bulletins are the primary reference. In accordance with 405 IAC 5-19-6, PA is required for most DME and HME rented or purchased with IHCP funds.

The Contractor shall provide coverage for Incontinence, Ostomy, and Urological Supplies based on Medical Necessity. The Contractor will assure that incontinence, ostomy and urological supplies can be delivered by mail to members. The Contractor may set a maximum allowable amount for incontinence supplies, but any maximum shall be at least as much or more than is covered by the IHCP FFS program.

3.14 24-hour Nurse Call Line

The Contractor shall provide nurse triage telephone services for members and informal caregivers to receive medical advice twenty-four (24) hours-a-day/seven (7)-days-a-week from trained medical professionals. The twenty-four (24)-hour Nurse Call Line should be well publicized and designed as a resource to members to help discourage inappropriate emergency room use, particularly for members in prevention and wellness programs(s)or receiving home and community-based supports through the waiver. Calls must be recorded. The 24-hour Nurse Call Line may share location information of nearby urgent care clinics within the Contractor's Medicaid and Medicare network (for dually-eligible members) and refer callers to 211, the suicide prevention hotline, LTC ombudsman, or Member Support Services contractor

as necessary. The 24-hour Nurse Call Line shall have a system in place to document and communicate all issues with the member's PMP and to the Contractor for referral to the member's care and service coordinator. The nurse call line shall collect data sufficient to meet care and service coordinators, member assistance, and reporting needs.

3.15 Opioid Treatment Program (OTP)

The Contractor shall provide coverage for the daily Opioid Treatment Program (OTP). A daily opioid treatment program includes administration and coverage of methadone, routine drug testing, group therapy, individual therapy, pharmacological management, HIV testing, Hepatitis A, B, and C testing, pregnancy tests, Tuberculosis testing, Syphilis testing, follow-up examinations, case management and one evaluation and management office visit every ninety (90) days for the management of member activities identified in the individualized treatment plan that assist in member goal attainment, including referrals to other service providers and linking members to recovery support groups. OTP coverage will include those members as defined by FSSA and approved by CMS. The Contractor will be responsible for OTP services provided by the provider type Addictions Provider and the provider specialty OTP as defined in the IHCP Provider Enrollment Type and Specialty Matrix.

OTP-eligible members include:

1. Members eighteen (18) years and older who have become addicted at least one year prior to admission and are placed in the Opioid Treatment Services (OTS) Level of Care according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

2. Members under eighteen (18) years of age and have had two documented unsuccessful attempts at short-term withdrawal management or drug free treatment within a twelve (12)-month period.

3. All members released from penal institution (within six (6) months of release).

4. Pregnant members.

5. Previously treated members (up to two (2) years after discharge).

3.16 Dental Services

Dental services are critical to ensuring the overall health of IHCP members. As such, dental services are a covered benefit under the [MLTSS Program Name] program per Exhibit 3 Program Description and Covered Benefits that the Contractor is responsible for managing and reimbursing. The Contractor will develop a comprehensive oral health strategy, in consultation with dental providers, that ensures appropriate utilization of this benefit by members consistent with dental standards of care.

3.17 Non-Emergency Medical Transportation Services

Non-emergency medical transportation (NEMT) services are a covered benefit under the [MLTSS Program Name] program per Exhibit 3 Program Description and Covered Benefits that the Contractor is responsible for managing and reimbursing. NEMT services are intended to assist members in accessing care due to a lack of transportation or insufficient resource to cover travel expenses. NEMT service may be utilized to access any covered non-emergency medical service, as well as support pharmacy and durable medical supply pick-ups and transport related to hospital discharges. The Contractor may provide transport to non-medical services at its own discretion and expense as an enhanced benefit, with State approval or through the waiver services. NEMT services must support both on-demand, acute care appointments and subscription medical services trips, including but not limited to dialysis, chemotherapy, radiology, and wound care. NEMT services must be provided to all enrolled members regardless of their residence type, including those members in institutional settings or transient/temporary living centers, such as shelters. In addition, NEMT must provide services to and from all Indiana counties and to all designated locations.

NEMT services cover a variety of modality types to ensure access for members regardless of mobility level. This includes ambulatory and bariatric transportation, wheelchair transportation, and stretcher transportation. In addition, the Indiana NEMT system utilizes Transportation Network Companies (TNCs) to provide on demand, backup network support to members who are ambulatory and meet other qualifications. Members must opt into using TNCs before each transport.

Under the Indiana Administrative Code 405 IAC 5-30-1.5, The Contractor must allow for gas and mileage reimbursement when the transportation is provided by a) an able-bodied member, b) a member's family member or c) a member's friend. All Contractors must offer gas/mileage reimbursement and pay a minimum per-mile rate as set annually by the Indiana Department of Administration. The Contractor must have a State-approved process for gas and mileage reimbursement authorization, scheduling and payment. Under the Consolidated Appropriations Act, 2021, Division CC, Title II, Section 209 the Contractor must provide for a mechanism, which may include attestation, that ensures any provider (including a transportation network company) or individual driver of non-emergency transportation to medically necessary services receiving payments under such plan (but excluding any public transit authority), meets specified minimum requirements. These minimum requirements under the State Plan must include that:

i. Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

ii. Each such individual driver has a valid driver's license;

iii. Each such provider has in place a process to address any violation of a state drug law; and

iv. Each such provider has in place a process to disclose to the State Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

3.17.1 Non-emergency Medical Transportation Providers and Provider Network

The Contractor shall provide an appropriate means of NEMT for individuals, who need transportation assistance and addresses the safety needs of the person with disabilities and/or special needs.

In accordance with Indiana Code, all NEMT providers must actively hold Indiana Motor Carrier Certification (unless exempt by law or carrier classification), secure and maintain liability insurance of $1,000,000 plus a $50,000 sexual molestation and abuse rider, and be enrolled as Medicaid provider in the Indiana Health Care Programs (IHCP). The Contractor is responsible for ensuring all initial certification and enrollment are complete prior to contract with a provider, as well as for monitoring the providers, including vehicle compliance inspections and driver education/training.

The Contractor is responsible for paying all provider claims, educating providers on claims processing rules and processing encounter data. NEMT expenses must be paid using the MCEs approved capitation payment. The Contractor will also ensure providers are claiming the most appropriate transportation benefit when a member is enrolled in the Contractor's aligned Dually-Eligible Special Needs Plan (D-SNP) and the D-SNP offers non-medical transportation benefits as part of its plan benefit package. The Contractor shall ensure sufficient communication and coordination with the relevant staff at its aligned D-SNP to ensure providers have sufficient awareness about how to access the appropriate member transportation benefit and accurately submit claims to the correct payer source.

The Contractor is responsible for establishing and growing an adequate transportation network inclusive of all modality types, including bariatric transports. The Contractor is responsible for provider relations with all transportation providers to ensure providers meet network participation requirements and understand their rights and responsibilities as well as all network participation policies and procedures. Sufficient and safe transportation must be available to members in all Indiana counties as well as out-of-state counties.

The Contractor is expected to provide transportation network adequacy GeoAccess maps that detail whether members have access to ambulatory, wheelchair, bariatric wheelchair, stretcher and bariatric stretcher within all ninety-two (92) counties. The Contractor must ensure the volume of available transportation providers is commensurate with demand for services, which will be measured at a minimum using data reports and member/provider complaints.

The Contractor must ensure that all driver staff receive cultural competency training as part of their onboarding and then annually thereafter.

The Contractor must also develop and submit to the state a driver/provider training curriculum to be used in onboarding and as a part of corrective action should issues arise.

3.17.2 NEMT Care Coordination

Care plans for members must include transportation needs and how those needs will be met. All [MLTSS Program Name] members shall be provided with a written summary of NEMT services and scheduling process upon enrollment. Transportation must be discussed during the initial care needs assessment and a least quarterly thereafter to ensure the member is not encountering barriers to accessing care. Care Coordinators should work with the member, caregivers and facilities as appropriate to develop the care plan ensuring the member's access to medical care and services. Care Coordinators should be available to troubleshoot issues, make changes to care plans as needed and provide education. The Contractor must have a clear, State-approved process to streamline scheduling standing orders, hospital discharges, and mileage reimbursement requests. The Contractor must also clearly detail how they will coordinate transportation benefits for members enrolled in both Medicare and Medicaid (dually-eligible),

especially if those members are enrolled in the Contractor's aligned D-SNP and the D-SNP offers non-medical transportation benefits as part of its plan benefit package.

The Contractor must allow for an escort to ride with the member if the member may require any of the following:

- Assistance loading or unloading into the vehicle
- Non-transportation related assistance during the trip, such as feeding or toileting-support
- Emotional support during transit or the medical appointment
- Care and cognitive support to understand diagnosis, ongoing procedures, doctor's instructions and/or other appointment-related information

Members shall not be required to provide evidence of their need for an escort. However, they do need to notify the Contractor during scheduling. In addition, the Contractor must ensure call center scheduling staff ask screening questions to determine if the member would be best served by having an escort.

The [MLTSS Program Name] members will require considerable transport to and from facilities, including dialysis, nursing facilities, assisted living, HCBS provider locations and member homes. Transportation must be available to members to and from all IHCP service locations and the member's residence, regardless of residence type. The Contractor is required to work with staff at facilities and provider locations to ensure a timely, accurate and safe transport as needed for members. Contractor staff should be available to assist in troubleshooting any issues.

3.17.3 NEMT Communications

The Contractor must operate a transportation call center that is available twenty-four (24) hours per day, seven (7) days per week and three hundred and sixty-five (365) days per year. There must be a dedicated facility provider line for scheduling and processing standing orders for transportation. The Contractor must operate a web-based scheduling service so provider facilities, caregivers and members can access assistance online, if they wish.

All The Contractor and Transportation Broker materials for providers must be State-approved. The Contractor is encouraged to develop materials to support facilities staff in securing appropriate transportation for [MLTSS Program Name] members, which also must be State-approved.

3.17.4 NEMT Brokers

If the Contractor chooses to utilize a NEMT broker, all requirements set forth by the State of Indiana will be applicable to the Contractor and the broker acting on their behalf.

3.17.5 Community Transportation

Community Transportation is a separate service covered for members receiving the HCBS benefit. Details on this service and expectations can be found in the IHCP manual. The Contractor may not utilize a transportation broker for the purposes of scheduling and payment of community transportation. The member's service coordinator shall assist with the scheduling of community transportation.

3.17.6 Attendant Care Aide Transportation

Transportation to both community and medical appointments is available for individuals utilizing the attendant care service. Details on the Attendant Care Aide Transportation service can be

found in the IHCP manual including requirements specific for medical transportation such as helping the member navigate the appointment itself and providing companionship during the trip.

3.18 Other Covered Benefits and Services

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

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

- The Contractor shall provide **Diabetic Supplies Coverage**. The Contractor shall cover diabetic supplies in alignment with FSSA's Preferred Diabetic Supply List (PDSL). The Contractor shall configure its claims payment system to approve the diabetic supplies of FSSA's contracted preferred vendors to supply blood glucose monitors and diabetic test strips for all IHCP enrollees. The Contractor shall adjudicate diabetic supplies through their PBM's point of sale system to ensure that NDCs are on the claim. The Contractor shall require prior authorization for all blood glucose monitors and diabetic test strips not on the PDSL.

3.19 Service Delivery Innovation

The Contractor must promote innovation in the [MLTSS Program Name] service delivery system, through collaborative efforts with FSSA, CMS, the State of Indiana, and local partners as well as innovation pursued on its own initiative. Indiana's focus on continuous system improvement results in the development of initiatives aimed at building a more cohesive and effective health care system in Indiana by reducing fragmentation, structuring provider reimbursements to further quality outcomes, leveraging health information technology, and working with private sector partners to further innovation to the greatest extent. The Contractor shall collaborate and be innovative in the implementation of these targeted initiatives:

- Person-centered Service Planning and Delivery,
- Whole person care,
- Equity,
- Care coordination and integration,
- Housing,
- Employment,
- Workforce Innovation,
- Telehealth services,
- Public/private partnerships,
- Electronic Visit Verification (EVV),
- Emergency Triage, Treat, and Transport (ET3),
- Payment modernization,
- Health Information Technology (HIT),
- Justice System transitions,
- Transportation, and
- Trauma informed care

3.20 Carved-out Services

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

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

3.20.1 Medicaid Rehabilitation Option (MRO) Services

The Contractor is not responsible for claims reimbursement for such services. However, the Contractor is responsible for ensuring care coordination, as described in Section 3.6.4, with physical and other behavioral health services for individuals receiving MRO services. See the Provider Reference Module Medicaid Rehabilitation Option Services for specific codes for MRO services.

3.20.2 1915(i) State Plan Home and Community-Based Services

The State has three (3) 1915(i) State Plan Home and Community-Based services programs: Behavioral and Primary Healthcare Coordination (BPHC), Adult Mental Health and Habilitation (AMHH) and Children's Mental Health Wraparound (CMHW). These services are carved-out of the Contractor's financial responsibility. The Contractor shall coordinate with 1915(i) services to prevent duplication and fragmentation of services. A listing of carved-out 1915(i) services is provided in the Provider Reference Module Medicaid Rehabilitation Option Services.

3.21 Excluded Services

The [MLTSS Program Name] program exclude some benefits from coverage under managed care. These benefits are available under traditional Medicaid or other waiver programs and are therefore excluded from the programs as described below. A member who is, or will be, receiving excluded services must be disenrolled from managed care in order to be eligible for the services. The Contractor is responsible for the member's care until the member is disenrolled from the plan unless stated otherwise. The [MLTSS Program Name] MCE Policies and Procedures Manual describe member disenrollment in greater detail.

Listed below are the services excluded from the [MLTSS Program Name] program.

3.21.1 Psychiatric Treatment in a State Hospital

[MLTSS Program Name] members receiving psychiatric treatment in a state hospital will be disenrolled from [MLTSS Program Name].

3.21.2 Intermediate Care Facilities for Individuals with Intellectual Disabilities

[MLTSS Program Name] members who are admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) shall be disenrolled from the Contractor and enrolled in Traditional Medicaid. Before the stay can be reimbursed by the IHCP, the level of care must be approved by the State. The Contractor must coordinate care for its members that are transitioning into an ICF/IID by working with the facility. The Contractor is responsible for payment for up to sixty (60) calendar days for its members placed in an ICF/IID while the level of care determination is pending.

3.21.3 Traumatic Brain Injury Waiver

The Traumatic Brain Injury waiver provides home and community-based services to individuals who, but for the provision of such services, would require institutional care. [MLTSS Program Name] members who become eligible for the Traumatic Brain Injury Waiver will be disenrolled from the Contractor and enrolled Traditional Medicaid.

3.21.4 Community Integration and Habilitation Waiver and Family Supports Waiver

The Family Supports Waiver and Community Integration and Habilitation Waivers are the two Medicaid Home and Community Based Services waiver programs for children and adults with intellectual and developmental disabilities. [MLTSS Program Name] members who become eligible for either waiver will be disenrolled from [MLTSS Program Name] and enrolled in Traditional Medicaid.

3.22 Continuity of Care

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

- Transitions for members receiving HIV, Hepatitis C and/or behavioral health services, especially for those members who have received prior authorization from their previous MCE or through fee-for-service;
- A member's transition into the [MLTSS Program Name] program from no coverage, commercial coverage, traditional fee-for-service, another managed care program;
- A member's transition between MCEs, particularly during an inpatient stay or skilled nursing facility stay;
- A member's transition between IHCP programs;
- A member's exiting the [MLTSS Program Name] program to receive excluded services;
- A member's transition to a new PMP;
- A member's transition to private insurance or Marketplace coverage; and
- A member's transition to no coverage.

For the first year of the program, the Contractor shall provide continuity of care for the authorization of services as well as choice of providers for one hundred and twenty (120) days. When receiving members from another MCE, fee-for-service, or commercial coverage, the Contractor shall honor the previous care authorizations for one of the following durations, whichever comes first: one hundred and twenty (120) calendar days from the member's date of enrollment with the contractor, or the remainder of the prior authorized dates or service, or until the approved units of service are exhausted. The Contractor shall establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's enrollment in their plan. For a member who meets HCBS Level of Care and has an existing care plan approved by FSSA or another MCE, that care plan will be honored for one hundred and eighty (180) calendar days from the date of enrollment. If the member's current medical or HCBS provider is not a contracted provider the Contractor shall provide for the continuation of care from that provider for at least one hundred and twenty (120) days, as long as the provider is IHCP enrolled. MCEs must have a

process to receive and transfer member information and the process must be managed by a transition coordinator.

After the first year of the program, the continuity of care period shall be ninety (90) days from the date of member enrollment for the authorization of services as well as choice of providers. The Contractor shall honor previous approved FSSA or other Medicaid MCE care plan for one hundred and eighty (180) days after year one (1) of the program.

Skilled nursing facilities are an exception to the continuity of care periods above. As skilled nursing facilities serve as the member's residence, forced transitions can cause adverse health outcomes. As such, the Contractor shall provide for continuity of care at the skilled nursing facility for the duration of the program, as long as the member chooses to remain in the facility. This applies only for members who continue to meet skilled nursing facility level of care.

The date of member enrollment for purposes of the prior authorization time frames set forth in this section begin on the date the Contractor receives the member's fully eligible file from the State.

Additionally, when a member transitions to another source of coverage, the Contractor shall be responsible for efficiently providing the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as prevention and wellness programs(s), case management or care management notes. This process shall be overseen by the transition Coordinator.

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

See Section 3.6.5 for additional requirements regarding continuity of care for behavioral health services. The [MLTSS Program Name] MCE Policies and Procedures Manual describes the Contractor's continuity and coordination of care responsibilities in more detail.

3.23 Out-of-Network Services

With the exception of certain self-referral services described in Section 3.2, and the requirements to allow continuity of care as described in Section 3.22, the Contractor may limit its coverage to services provided by in-network providers once the Contractor has met the network access standards set forth in Section 6. However, in accordance with 42 CFR 438.206(b)(4), which relates to coverage of out-of-network services, the Contractor shall authorize and pay for out-of-network care if the Contractor is unable to provide necessary covered medical services within the required time, distance, and access standards within this contract by the Contractor's provider network. In addition, upon at least thirty (30) calendar days advance notice, the State may also require the Contractor to begin providing out of network care in the event the Contractor is unable to provide necessary covered medical services within the Contractor's provider network within specified timeliness standards defined by the State.

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

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

authorized, routine care provided to its members by out-of-network providers.

Except for situations listed in Section 2.8 the Contractor shall reimburse any out-of-network provider's claim for authorized services at a negotiated rate, or in the absence of a negotiated rate, an amount equal to or higher than ninety-eight percent (98%) of the Medicaid fee-for-service rate.

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

3.24 Enhanced Services

The State encourages the Contractor to cover programs that enhance the general health and quality of life of its [MLTSS Program Name] members, including programs that address preventive health, risk factors or quality of life. These enhanced programs and services are above and beyond those covered in the [MLTSS Program Name] program.

In addition, all enhanced services shall comply with the member incentives guidelines set forth in Section 7.7 Member Incentive Programs and other relevant state and federal rules regarding inducements. All enhanced services offered by the Contractor must be pre-approved by OMPP prior to initiating such services.

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

- Enhanced transportation arrangements (i.e. transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, etc.);
- Enhanced tobacco dependence treatment services;
- Prevention and Wellness Programs or incentives beyond those required by the State in Section 3.7;
- Healthy lifestyle incentives;
- Group visits with nurse educators
- Medical equipment or devices not already covered under the [MLTSS Program Name] program to assist in prevention, wellness, or management of chronic conditions; and
- Cost effective supplemental services which can provide services in a less restrictive setting.

While member enhancements and incentives can be powerful tools, these programs need to be thoughtfully designed to ensure there are no unintended consequences, for example increasing disparities or limiting access. To this end, the State has developed guidance to encourage the Contractor to consider the following set of guiding principles in their design and implementation as building blocks of member enhancements and incentives:

- Culturally sensitive – Ensuring cultural sensitivity is necessary to provide successful outcomes, as cultural norms differ and may need to be incentivized differently;

- Unbiased – Creating unbiased enhancements and incentives are necessary to comply with federal laws. Incentives must not leave out any groups on the basis of ethnicity, education, race, social class, ability, etc.);

- Possess equity – Equality is not enough when providing enhanced services and incentives, rather maintaining equity should also be considered (equality would be providing a pair of size 10 shoes to everyone; equity is providing a pair of the correct size shoes to everyone);

- Communicated appropriately in a timely manner – Incorporate the most appropriate and farthest reaching vehicle to communicate the enhanced benefit and incentive so as not to exclude members (e.g., lack of literacy and technology should be considered). Appropriate messaging should capture high quality outcomes;

- Be relevant – If barriers exist that prevent members from using the enhanced service and incentive, the incentive will not hold much value (e.g., a member is given a gym membership as an incentive but does not have the transportation to get to the gym).

It is important to note the process of designing member enhanced services and incentives is complex and the Contractor will need to consider underlying disparities and SDOH including community needs, and local planning efforts. Member enhanced services and incentives must not reinforce disparities or perpetuate inequality within or between communities, particularly in terms of how disparate subpopulations access wellness services and support.

3.25 Residential Substance Use Disorder (SUD) Services

Short-term low-intensity and high intensity residential treatment for opioid use disorder (OUD) and other substance use disorder (SUD) in settings of all sizes, including facilities that qualify as institutes of mental disease (IMDs) are a covered benefit under the [MLTSS Program Name] program per Exhibit 3 Program Description and Covered Benefits that the Contractor is responsible for managing and reimbursing.

Prior authorization (PA) is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria:

1. ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services
2. ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

When residential services are determined medically necessary for a member, the Contractor will approve a minimum of fourteen (14) days for residential treatment, unless the facility requests fewer than fourteen (14) days. If a facility determines that a member requires more time than the initial fourteen (14) days, the facility should submit a PA update request showing that the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity.

3.26 Inpatient Hospitalization Notification

With appropriate consent, the Contractor shall notify a member's physician when a member is hospitalized or receives Emergency treatment. This notice must be provided within five (5) calendar days of the hospital inpatient admission or Emergency treatment. The Contractor shall maintain strategies to receive hospital notification of inpatient admissions to facilitate meeting this requirement, for example, through the use of incentive programs.

3.27 Medication Therapy Management Services

The Contractor shall cover Medication Therapy Management (MTM) services~~.~~ in accordance with this Section which outlines goals, general requirements, target profile and reporting requirements (hereinafter, "guidelines").

3.27.1 Goals of the MTM Program

The goals listed below must remain at the forefront of the program processes implemented by the Contractor on behalf of [MLTSS Program Name] members who are identified as high risk due to a combination of chronic disease state and multiple unique prescribed medications. The MTM program implemented must:

- Be member focused;
- Improve medication use;
- Reduce risk of adverse events; and
- Improve adherence.

3.27.2 General Requirements

The general requirements are based on the CMS Medicare Part D MTM program requirements. While members may refuse to participate in the MTM program, the MTM activities which do not require the member's direct involvement shall continue to be performed by the Contractor. The Contractor shall continue to work with members who do not participate in, or cooperate with, the program. A significant part of MTM involves reviewing members' medication profiles looking for drug-drug interactions, drug-disease interactions, adverse reactions, drugs added to counteract side effects of other drugs, or drugs added that have redundant mechanisms of action and thereby increase the risk of toxicity. All of the aforementioned involve interventions with the prescriber and do not necessarily require member interaction. The Contractor is expected to retain metrics for members with whom the Contractor attempts to engage but refuse to participate or cooperate. The Contractor shall continue to attempt to involve those members and shall attempt to engage non-participating members, at minimum, on an annual basis.

The MTM program must:

- Provide interventions (e.g., Comprehensive Medication Review, Targeted Medication Review, review concerns members have about their medications, make recommendations to providers and members about medications) to be performed by registered pharmacists or other licensed medical professionals such as nurses, nurse practitioners, prescribers and other physicians.
- During the first four (4) months after Contract initiation, as members transition to [MLTSS Program Name], the Contractor must engage targeted members within one hundred eighty (180) days. Following this four (4) month period, the Contractor must engage new members targeted for MTM within sixty (60) days.
- Continue working with members who do not participate in, or cooperate with, the program. A significant part of MTM involves reviewing members' medication profiles looking for drug-drug interactions, drug disease interactions, adverse reactions, and drugs added to counteract side effects of other drugs. All of the aforementioned involve interventions with the prescriber and do not necessarily require member interaction.
- Interact with engaged members, following the initial MTM service, on a frequency as determined by the Contractor, based on member need, but not less than once per year.
- Include members with the following targeted conditions:
    - Alzheimer's Disease and other Dementias
    - Chronic Heart Failure (CHF)
    - Diabetes
    - Dyslipidemia
    - End-Stage Renal Disease (ESRD)
    - Hypertension
    - Respiratory Disease (i.e. Asthma, COPD, CF, etc.)
    - Bone Disease (i.e. Arthritis, Osteoporosis, Osteoarthritis, Rheumatoid Arthritis)
    - Mental Health Disorders (i.e. Depression, Psychosis, Schizophrenia, Bipolar Disorder, etc.)
    - Neuromuscular Disorders (i.e. Multiple Sclerosis, Parkinson's Disease)
    - Viral Disease (i.e. Hepatitis C, HIV, AIDS)

In performing MTM functions, the Contractor must demonstrate a thorough understanding of the federal regulations and guidelines which direct the monitoring, oversight, intervention and reporting of psychotropic drug utilization in children and adolescents. Further, in performing MTM functions the Contractor must collaborate and cooperate with the prescriber interventions made as a result of the Indiana Psychotropic Medication Initiative.

3.27.3 Comprehensive Medication Review (CMR)

The Contractor must offer a minimum level of CMR services to each member enrolled in the program that includes interventions with members and prescribers.

CMR must include:

- Medication action plan;
- Personal medication list;
- Summary of recommendations; and
- Medication refill reminders.

3.27.4 Target Members

The Contractor's MTM program is expected to target members.

Targeted members must meet all of the following criteria:

- Have three or more (3+) of the targeted conditions in Section 3.27.2 based on drug claims; and
- Eight or more (8+) chronic drug claims within the past 12 months.

3.27.5 Reporting

Reporting is a critical factor in determining effectiveness of individual MTM programs as well as the MTM program for all Indiana Medicaid members. OMPP retains the authority to request reporting and metrics, as appropriate, to determine effectiveness of individual programs. Minimum requirements for reporting include semi-annual reporting. Reporting requirements include, but are not limited to the following:

- Number of members enrolled;
- Average number of disease states;
- Top 5 (five) disease states engaged;
- Measure of return on investment (ROI);
- Change in adherence rate for enrolled members; and
- Measure of member/provider satisfaction.

4.0 Care Coordination

4.1 Care Coordination Program Overview

Prior to Contract start date and on an annual basis, the Contractor shall submit for approval to the State a [MLTSS Program Name] Care Coordination Program Plan. The Contractor's Care Coordination Program Plan must receive approval before member stratification. The Care Coordination Program Plan shall include, but not be limited to, descriptions of how the Contractor shall comprehensively address the following Care Coordination critical elements and their associated factors: Care Coordination Staff Structure, Comprehensive Health Assessments, Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT), Continuity of Care and Care Transition Protocols. The Contractor's Care Coordination Program Plan and service delivery must contain evidence of person-centered practices. The State strongly encourages a strengths-based approach in all aspects. A Contractor's Care Coordination Program must include both Care Coordination and Service Coordination and compliment the Contractor's companion D-SNP Model of Care (MOC).

The Contractor must offer all members person-centered Care Coordination reflective of their needs to assist them in planning, accessing, and managing their health care and health care-related services. The Contractor shall provide a minimum of two Care Coordination levels of service: Care Management and Complex Case Management. Care Management must be available to all members, while Complex Case Management must be available to high-risk/high-need members who meet State-defined criteria (Section 4.11.2). All members regardless of their assigned Care Coordination level of service must have an

assigned Care Coordinator to facilitate the development of a longitudinal and trusting relationship with each member toward improved quality, continuity and coordination of care.

In addition to Care Coordination services, all members who are determined Nursing Facility Level of Care (NFLOC) and receive HCBS or institutional LTSS will be eligible for Service Coordination for their LTSS and related environmental and social services. Service Coordination specifically focuses on supporting members in accessing long-term services and support, medical, social, housing, educational, and other services, regardless of the services' funding sources. All members receiving Service Coordination will have an assigned Service Coordinator who works with the member's Care Coordinator to ensure cohesive, holistic service delivery. At the outset of the [MLTSS Program Name] program, the Contractor shall provide Service Coordination to at least 50% of its enrolled members receiving HCBS waiver services through current Aged & Disabled waiver care management entities. The list of current care management entities will be provided to the Contractor by the State. This requirement shall be in place for the two initial Contract years. Examples of approved waiver care management entities include the Area Agencies on Aging, a network of care management providers, and independent care management providers.

To increase the integration of care and the improvement of health outcomes that the alignment of Medicaid and Medicare systems could provide, the Contractor must use the same CMS-approved MOC as the Contractor uses in their exclusively aligned companion D-SNP as the foundation of their [MLTSS Program Name] MOC to provide care management, regardless of the members' Medicare eligibility. In cases where the Contractor's companion D-SNP's CMS-approved MOC does not meet Indiana [MLTSS Program Name] standards as described herein, the Contractor shall modify or adapt its companion D-SNP's CMS-approved MOC approaches to meet the requirements below in Section 4 when delivering Care Coordination services to [MLTSS Program Name] members.

In addition, the Care Coordination Program Plan may be modified if the Contractor receives written approval from FSSA.

4.2 Care Coordination Levels of Service and Stratification

Based on the results of the Contractor's initial screening (see Section 4.5) as well as mining of historical claims data and clinical data (when available) from health information exchanges, the Contractor shall stratify its membership into various subpopulations to identify member level of service and ensure continuity of care. The outcome of the member assessment set forth in Section 4.6 will determine the member's needs in the stratification process resulting in the member's assignment to one of the levels of care coordination service, which include at a minimum: Care Management and Complex Case Management, as set forth below in this Section. Additionally, members may be enrolled in the Right Choices Program (RCP) level of service as described in Section 4.2.4.

Prior to the Contract's effective date, the Contractor will propose to FSSA a stratification methodology, which shall include a "rush" designation for members with immediate needs. The stratification plan must be approved by FSSA prior to member stratification. In addition, the care coordination classification system may be modified if the Contractor receives written approval from FSSA.

In addition to any assigned Care Coordination level of service, members who are determined to be Nursing Facility Level of Care (NFLOC) and receiving LTSS in a home, community, or institutional setting are eligible to receive LTSS-specific Service Coordination. The Contractor shall include members who are eligible for Service Coordination when risk stratifying its entire population.

The Contractor's stratification methodology shall include a section that describes how the Contractor integrates a Service Coordination-eligible member's information with other Contractor activities, including but not limited to, Utilization Management (UM), and Care Coordination levels of service to assure programs are linked and members receive appropriate and timely care.

As part of the Contractor's Care Coordination Program, the Contractor shall place Service Coordination-eligible members into appropriate Care Coordination programs and/or stratification within a program, not only according to risk level or other clinical or member-provided information but also by the type of setting in which long-term care services are delivered, i.e., nursing facility, community-based residential alternative, or home-based. The targeted interventions for Service Coordination-members should not only be based on risk level but also based on the setting in which the member resides. Under no circumstances shall a member receiving Service Coordination be stratified or assigned to the Contractor's lowest Care Coordination level of service. The Contractor's Service Coordination-eligible member section of their Care Coordination Program Plan must address how the Contractor shall ensure that, upon enrollment into Service Coordination, Service Coordination activities including informal caregiver supports and informal caregiver coaching are integrated with the member's assigned Care Coordination level of service processes and functions and that the member's assigned Service Coordinator has primary responsibility for coordination of the member's LTSS and LTSS-specific person-centered support plan ("Service Plan"), which must be integrated into the member's overall Individualized Care Plan (See Section 4.9). A member's Service Coordinator shall be a core participant in the member's Interdisciplinary Care Team (ICT) and collaborate with the member's Care Coordinator, who has primary responsibility for coordination of the member's physical and behavioral health.

Service Coordination staff shall supplement, but not supplant, the role and responsibilities of the member's Care Coordinator and ICT. The Service Coordinator may use the Contractor's applicable Care Coordination Program's tools and resources, including staff with specialized training, as needed in coordination with the member's Care Coordinator and ICT, to help manage the member's condition(s) in a holistic manner.

The Contractor shall develop and operate all Care Coordination levels of service using an "opt out" methodology. The Contractor's opt out process shall be submitted to the State as part of the Care Coordination Program Plan for review and approval before implementation. Care Coordination services shall be provided to all eligible members unless they specifically ask to be excluded. The Contractor shall not engage in any activities that encourage members to exclude themselves from Care Coordination or Service Coordination.

4.2.1 Care Management

Care Management is the foundational Care Coordination level of service that shall be made available to all [MLTSS Program Name] members and is intended to provide members with assistance with care coordination activities, making preventive care appointments, and/or accessing care for needed health or social services to address the member's chronic health condition(s). Care Management entails a purposeful plan to reach members and impact their health and health care utilization and to coordinate all services provided to members. Care Coordinators shall also assist with fair hearing requests when needed and requested.

Through Care Management, the Contractor assists members in improving their health outcomes. The Contractor will provide comprehensive coordination services that are tailored to the individual, rely on sound medical practices, and include Medicaid-covered services. For members who are not determined to meet NFLOC and who have an informal caregiver, the Contractor shall also assist the member's identified, informal caregiver in accessing resources, including training and education, appropriate and applicable to the member and caregiver's needs, in alignment with Section 3.11.1.

Care Management services include coordination of care across providers and direct consumer contacts to assist members with scheduling, location of specialists and specialty services, intellectual and developmental disability services, transportation needs, twenty-four (24)-hour nurse call line use, general preventive (e.g. mammography) and disease specific reminders, pharmacy refill reminders, tobacco cessation and education regarding use of primary care and Emergency services. The Contractor must conduct the minimum member contacts and outreach, as described in Section 4.11.1, for all members assigned to Care Management.

At the time of enrollment, members may be receiving case management services through Community Mental Health Centers (CHMCs). The Contractor will educate the member on care coordination delivery options upon and throughout their enrollment and support the member to determine the services the eligible member will receive from the CMHC. The member's preferences shall be documented in the member's care plan. The CMHC and Contractor shall work closely together and engage in regular meetings to discuss issues and progress to ensure the member receives appropriate services that are not duplicated.

4.2.2 Complex Case Management

Complex Case Management is for members with:

- three (3) or more disease states which require the ongoing involvement of sub-specialists to manage and deliver disease-appropriate care or
- two (2) or more "uncontrolled" disease states which are defined as disease states requiring immediate attention, for which the member is not currently receiving disease-appropriate screening, follow-up appointments, care, therapy, and/or medication or
- Alzheimer's disease and related dementias (ADRD) or
- an active cancer diagnosis or the "uncontrolled"/ "uncompensated" disease states of heart failure or COPD or diabetes with an A1C of greater than 9.0% or
- palliative care service needs or
- serious mental illness or
- substance use disorder (SUD) or
- significant cognitive impairment or
- high dollar claims of over fifty thousand $50,000 dollars (>$50,000) in six (6) months or
- a NFLOC determination and are receiving LTSS in a home or community-based setting or
- housing stabilization needs.

The Contractor must provide Complex Case Management services for members discharged from an inpatient psychiatric or substance use disorder hospitalization, for no fewer than ninety (90) calendar days following the inpatient hospitalization. The Contractor must also provide Complex Case Management services for any member at risk for inpatient psychiatric, drug overdose, or substance abuse re-hospitalization.

Complex Case Management includes all the services and benefits from Care Management. Complex Case Management involves the active coordination of care and services with the member and between providers while navigating the extensive systems and resources required for the member. It includes the Comprehensive Health Assessment, determination of available benefits, development and implementation of an ICP, which includes specific objectives, goals and action protocols to meet the member's identified needs, as established through a person-centered planning process and ICT collaboration.

For members who are assigned to Complex Case Management level of service but are not determined NFLOC, the member's Care Coordinator shall be responsible for the coordination of all the member's needed medical and non-medical services, including functional, social, and environmental services.

The Contractor must conduct the minimum member contacts and outreach, as required in Section 4.11.2 of this Contract, for all members assigned to Complex Case Management.

Avoidance of unnecessary Emergency department and inpatient hospitalizations and increased use of preventive health care are goals for Complex Case Management.

4.2.3 Complex Case Management and Service Coordination

In addition to Complex Case Management, members who are determined NFLOC and receive LTSS shall receive LTSS-specific Service Coordination.

Service Coordination is a process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic LTSS and related environmental and social needs of each individual. The Service Coordinator is responsible for the development and implementation of the LTSS-specific person-centered support plan ("Service Plan") and for assisting members in gaining access to long term services and supports, as well as medical, social, housing, educational, and other services, regardless of the funding source for the services, to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for institutional placement. The Service Coordinator shall collaborate with the member's Care Coordinator and provide for the regular review and modification of the member's LTSS-specific Service Plan with the member, their caregivers with the consent of the member, and the member's ICT.

4.2.4 Right Choices Program

The Right Choices Program (RCP) is Indiana's restricted card program. The purpose of the RCP is to identify members who use covered services more extensively than their peers and/or exhibit drug-seeking behaviors. The program, set forth in 405 IAC 1-1-2(c) and 405 IAC 5-6, is designed to monitor member utilization, and when appropriate, implement restrictions for those members who would benefit from increased care coordination. The RCP follows the CMS design of a Patient Review and Restrict (PRR) program that is focused on behaviors of Doctor Shopping and excessive utilization of Controlled Substances, especially Opioids. The Contractor will provide appropriate prevention and wellness programs(s), care management, or complex case management services to the RCP members.

Program policies, set forth by the FSSA for the RCP, are delineated in the Right Choices Program Policy Manual. The Contractor shall comply with the program policies set forth in the Right Choices Program Policy Manual, which is provided in the Bidders' Library. The Contractor shall be responsible for RCP duties for their members, as outlined in the Right Choices Program Policy Manual, including, but not limited to, the following:

- Evaluate claims, medical information, referrals, and data to identify members to be enrolled in the RCP. Before enrolling a member in the RCP, the Contractor must ensure a physician, pharmacist, or nurse confirms the appropriateness of the enrollment;
- Enroll members in the RCP;
- Provide written notification of RCP status to such members and their assigned primary physicians and pharmacies;
- Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management, and care coordination with the goal of modifying member behavior;
- Provide appropriate customer service to providers and members;
- Evaluate and monitor the member's compliance with their treatment plan to determine if the RCP restrictions should terminate or continue;

- Notify FSSA of members that are being reported to the FSSA Bureau of Investigation for suspected or alleged fraudulent activities;
- Provide ad-hoc reports about RCP to FSSA upon request;
- Cooperate with FSSA in evaluation activities of the program by providing data and/or feedback when requested by FSSA;
- Meet with FSSA about RCP program implementation as requested by FSSA; and
- Develop, for FSSA approval, and implement internal policies and procedures regarding the Contractor's RCP program administration.

4.3 MLTSS and Medicare Care Coordination Alignment

The [MLTSS Program Name] population will include members in the following three categories based on Medicaid and Medicare eligibility and enrollment alignment:

- "Medicaid Only," which includes members who are solely Medicaid eligible and enrolled in only [MLTSS Program Name]
- "Dual Eligible – Aligned," which includes dually eligible members who are enrolled in both the Contractor's [MLTSS Program Name] program and the Contractor's exclusively aligned companion D-SNP
- "Dual Eligible – Unaligned," which includes dually eligible members who are enrolled in the Contractor's [MLTSS Program Name] program and any unaligned Medicare service delivery system. This would include enrollment in traditional Medicare, any non-SNP Medicare Advantage Plan, Chronic Condition Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs).

Members may change between the above three categories frequently and unpredictably. As such, the Contractor must maintain staff capability and systems capacity to identify, reassess, and recategorize members swiftly and according to their changing Medicaid and Medicare eligibility and enrollment status.

The Contractor's Care Coordination Program Plan shall describe how the Contractor plans to deliver Care Coordination and Service Coordination services to members in each of the three categories, "Medicaid Only," "Dual Eligible – Aligned" and "Dual Eligible – Unaligned." At a minimum, the Contractor must ensure the member's Care Coordinator coordinates with all Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

For dually eligible members, the Contractor must describe how it intends to maximize the integration of Medicare and Medicaid services and promote the seamless coordination of their care. For members in the "Dual Eligible – Aligned" category, this may include but is not limited to an integrated assessment and care coordination process that spans all MA and Medicare services, including behavioral health services. The "Dual Eligible – Aligned" member's Care Coordinator and the companion D-SNP's staff shall be responsible for coordinating the full range of Medicaid, including LTSS, and Medicare benefits, have access to all of the information needed to do so, and the Contractor's systems and business process shall support an integrated approach to care coordination and service delivery. Administrative integration is expected to evolve over the life of the MLTSS program. The Contractor will cooperate fully with the State and CMS in their ongoing efforts to streamline administration of the two programs, which may include, but is not limited to, coordinated readiness reviews, monitoring, enrollment, member materials and appeals processes. The Contractor shall respond to requests from the State for its companion D-SNP's operational, benefit, network, financial and oversight information that directly impacts the continued integration of Medicare and Medicaid benefits in order to maintain a seamless service delivery of Medicare and Medicaid benefits to members. The Contractor shall identify and include all necessary

parties from both the [MLTSS Program Name] and its aligned D-SNP in requests and responses to avoid administrative duplication.

The Contractor shall coordinate all Medicare and Medicaid services for its full-benefit dually eligible members. Please see Section 2.21 for additional requirements, regarding the Contractor's responsibilities for the heightened integration of Medicare and Medicaid services and administrative alignment across the two programs. The Contractor shall be responsible for ensuring seamless coordination of discharge planning on behalf of members enrolled in its companion D-SNP (Dual Eligible – Aligned) and for coordinating with other Medicare payors and plans, including traditional Medicare, unaligned Medicare Advantage plans, Chronic Conditions Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs) for members who are "Dual Eligible – Unaligned". This shall include, but not be limited to the appropriate triage of inpatient admission notifications and coordination in discharge planning when Medicaid LTSS or other Medicaid services are needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective, and integrated setting. The Contractor is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare.

For members in "Dual Eligible – Unaligned" category, the Contractor shall request, when appropriate and available, the member's Medicare payor or plan's participation in needs assessments and/or the development of an integrated person-centered plan of care for the Contractor's [MLTSS Program Name] member, encompassing Medicare benefits provided by the payor or plan as well as Medicaid benefits provided by the Contractor. To the extent possible, the Contractor shall establish protocols and systems to share necessary data across payors, plans, and programs to facilitate an effective care coordination process for "Dual Eligible—Unaligned" members.

4.4 Subpopulations at Greater Risk for Negative Health Outcomes

The Contractor is expected to develop and deliver tailored services for member subpopulations at greater risk for negative health outcomes. The Contractor's Care Coordination Program Plan must describe the member subpopulations at greater risk for negative health outcomes within the [MLTSS Program Name] population (i.e., what sets them apart from the overall [MLTSS Program Name] population), the methodology used to identify them (e.g., data collected on multiple hospital admissions within a specified time frame; high pharmacy utilization; high risk and resultant costs; specific diagnoses and subsequent treatment; medical, psychosocial, cognitive or functional challenges) and the specially tailored services for which these members are eligible. The Contractor must provide information about its local target population in the service areas covered under the Contract; information about national population statistics will be considered insufficient for this purpose.

The Contractor's Care Coordination Program Plan's definition of its subpopulations at greater risk for negative health outcomes members must describe the demographic characteristics of this population (i.e., average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factors such as trauma) and specify how these characteristics combine to adversely affect health status and outcomes and affect the need for unique clinical interventions. The definition must include a description of special services and resources the Contractor anticipates for provision of care to these member subpopulations at greater risk for negative health outcomes.

The Contractor's Care Coordination Program Plan must describe the Contractor's process for partnering with providers within the community to deliver needed services to its subpopulations at greater risk for negative health outcomes, including the type of specialized resources and services provided, and how the Contractor works with its partners to facilitate member or caregiver access and maintain continuity of services.

As part of the annual Care Coordination Program review process, the State may identify new or changing groups or subpopulations of members at greater risk for negative health outcomes, which the Contractor

must incorporate into its definition for subpopulations of members at greater risk for negative health outcomes and address through specially tailored services.

4.4.1 State-identified Members at Greater Risk for Negative Health Outcomes

As part of its annual Care Coordination Program Plan, the Contractor must propose evidence-based practices and specific approaches for coordinating the care of members who have or meet the following State-identified statuses, conditions, and/or needs:

- Alzheimer's disease and related dementias (ADRD)
- High-risk of falls
- Palliative care, hospice and end-of-life care
- Informal caregiver stress or loss
- High-risk of social isolation/loneliness especially if a member does not have informal caregiver support and lives alone
- Housing insecure or homeless
- Polypharmacy in need of medication management
- Enteral and parenteral nutrition
- Previously incarcerated
- Adult protective services
- Inpatient Psychiatric Care
- Intellectual and Developmental Disabilities
- Severe Mental Illness (SMI)
- Substance Use Disorder (SUD)
- High dental needs
- Ventilator-dependent

The Contractor must describe how it will identify members or use data sent by the State to identify members with the above statuses, conditions, or needs for inclusion in a specific Care Coordination program or stratification within a program; identify and address condition or need-specific goals/objectives; and ensure each goal/objective is integrated into or otherwise reflected in the member's care assessment(s), Interdisciplinary Care Team (ICT) resources, Individualized Care Plan, Service Plan (if applicable), and service delivery. The State reserves the right to require the Contractor to address new or revised State-identified statuses, conditions, and/or needs to reflect new or changing subpopulations at greater risk for negative health outcomes. Over the life of the Contract, the State reserves the right to mandate that the Contractor adopt State-identified best practices in the identification, treatment, and/or coordination of care of specific groups and members at greater risk for negative health outcomes.

4.5 Initial Screening

The Contractor shall conduct an initial screening of each member within thirty (30) calendar days of the effective date of enrollment to identify the member's immediate physical and/or behavioral healthcare needs and facilitate the member's assignment to the appropriate Care Coordination level of service as detailed in Section 4.2. The Contractor must make at least three subsequent attempts on different days to conduct an initial screening of each member's needs if the initial attempt to contact the member is

unsuccessful. The Contractor shall make attempts to find a member's current contact information if it is not included in the enrollment file. The Contractor shall use the FSSA Health Needs Screening tool.

In addition to the completion of the FSSA Health Needs Screening tool, initial screening and stratification activities include a review of the member's claims history (when available), identification of access or accommodation needs, language barriers, or other factors that might indicate the member's communication preferences. The initial screening shall also identify members who have complex or serious medical conditions that require an expedited appointment with an appropriate provider. The initial screening will ensure that members who are in ongoing treatment receive assistance in accessing appropriate care in order to avoid disruptions in services. The initial screening must include a review of important relevant, available clinical information such as the provider's assessment of conditions and the severity of illness, treatment history and outcomes, other diseases, illnesses, and health conditions as well as the member's immediate psychosocial, support, behavioral health and treatment needs. Through data analysis and predictive modeling, the Contractor will identify members who are at the highest risk for hospitalization or relapse, or high cost and/or high utilization in the future.

At a minimum, the initial screening shall:

- Utilize the FSSA Health Needs Screening tool
- Utilize claims data, health information exchange data, information gathered in the screening, medical records and other sources, as available;
- Identify gaps in member's care and facilitate communication to relevant providers, including the member's PMP, if applicable;
- Identify any immediate physical and/or behavioral health needs;
- Determine need for Care Coordination levels of service and LTSS-specific Service Coordination;
- Determine need for a referral of the member for a NFLOC assessment and determination;
- Conduct review of clinical history;
- Gather information regarding level and type of existing care management; and
- Provide an option for members to decline Care Coordination and/or Service Coordination with information on how members can opt back in at any time.

4.6 Comprehensive Health Assessment

The Contractor shall conduct a Comprehensive Health Assessment using a State-developed Comprehensive Health Assessment Tool (CHAT) of all members following the initial screening in order to further identify the appropriate services, programs, and Care Coordination level of service for the member. The Comprehensive Health Assessment will be all-inclusive and identify the clinical, psychosocial, functional and financial needs of the member to ensure appropriate referrals to MCE programs and community-based organizations. The CHAT shall be completed according to the timeframes below and will be used to develop and implement an ICP to meet the member's needs.

a. For members who are receiving LTSS in a nursing facility at the time of enrollment, the Contractor shall conduct the Comprehensive Health Assessment or State-approved nursing facility assessment(s) (Section 4.8.1) onsite within thirty (30) calendar days of the MCE effective date.

b. For members who meet NFLOC and are either receiving HCBS, waiting to receive, or opt to receive HCBS at the time of enrollment, the Contractor shall conduct the Comprehensive Health Assessment onsite within thirty (30) calendar days of the MCE effective date.

c. For enrollees who do not meet NFLOC and are not receiving LTSS in an institutional, home, or community-based setting at the time of enrollment, the Contractor shall conduct a Comprehensive Health Assessment onsite or by phone within ninety (90) calendar days of the MCE effective date.

An on-site visit shall be conducted to develop the member's ICP at the member's place of residence (or another location of the member's preference) for members who are enrolled while receiving or waiting to receive HCBS or at an institutional setting for members who are enrolled during a hospital stay or while residing in a facility. Confirmation of the scheduled on-site visit is recommended prior to the meeting. The member shall be present for, and be included in, the on-site visit. The member is always central to the assessment process, and all aspects of the care planning and assessment processes involving the participation of the member must be timely and occur at times and locations consistent with the requirements herein.

The Contractor shall inform members that they may request the Comprehensive Health Assessment be conducted in alternative modes, such as by phone or virtual visit, or settings, besides at the member's place of residence or service location. Upon request and to the extent possible, the Contractor shall coordinate with the member and/or the member's family member, informal caregiver, Supported Decision Maker(s), legal guardian, and/or Designated Representative to conduct the Comprehensive Health Assessment in a mode or setting convenient to the member and member's circle of support and reflective of the member's expressed preferences. The Contractor may outreach to members to inquire if the alternative Comprehensive Health Assessment arrangements are the desired mode/setting for follow-up assessments and reassessments.

The member's family member, legal guardian, informal caregiver, Supported Decision Maker(s), and/or Authorized Representative (as applicable and/or determined by the member) shall be contacted for the Comprehensive Health Assessment and care planning meeting, including establishing service needs and setting goals, if the member is unable to participate. For members in need of services provided by the LTC Ombudsman, the Contractor shall, as appropriate, invite an LTC Ombudsman staff person to participate in the member's assessment and reassessment process for both the CHAT and any LTSS-specific assessments for those members who qualify for Service Coordination in accordance with Section 5.13.

The State-developed CHAT shall include a functional assessment based on the interRAI and a social determinants of health (SDOH) questionnaire based on the Accountable Health Communities (AHC) Model. The CHAT shall also include an assessment of vulnerability and risk factors for abuse and neglect in the member's personal life or finances including an assessment of the member's potential vulnerability/high risk per Section 5.13. Completion of this component of the CHAT shall be documented in the member record. The CHAT may be augmented with condition specific and/or Contractor specific elements upon review and approval by FSSA. The Comprehensive Health Assessment shall include the same components as the State-determined Level of Care (LOC) assessment, and the Contractor shall be responsible for sending applicable CHAT results to a state-designated enrollment partner for members in need of a NFLOC determination. Additionally, should a member receive the LOC assessment prior to receiving the Comprehensive Health Assessment from the Contractor, the Contractor must be able to electronically receive and act upon the resulting NFLOC determination and incorporate any LOC assessment results provided by any state-designated enrollment partners (e.g., hospital, AAA, vendor, etc.) into the CHAT on behalf of the member, in lieu of readministering the corresponding components of the CHAT to the member during the Comprehensive Health Assessment process. The Contractor must collaborate where possible with other contractors and Medicare plans (see Section 4.3) to receive, process, and incorporate the results of assessments equivalent to individual CHAT components to reduce member burden by preventing the need for duplicative assessments.

As part of the Comprehensive Health Assessment process, the Contractor shall work with the member and collect and review medical and educational information, as well as family and caregiver input, as appropriate, to identify the member's care strengths, health needs and available resources. The Comprehensive Health Assessment may include, but is not limited to, a review of the member's claims

history and contact with the member and/or member's family, their informal caregiver, PMP (if applicable), or other significant providers with the consent of the member. A clinician on the Contractor's Care Coordination team will review the findings of the CHAT and provide the findings to the member's ICT and primary providers, including the member's PMP and/or behavioral health care providers, as applicable.

The results of the Comprehensive Health Assessment shall be incorporated into the member's record and be made available to the member's ICT for Care Coordination and Service Coordination activities, as applicable. For members who receive Service Coordination in addition to Care Coordination, the Contractor shall ensure that the member's Service Coordinator and ICT are provided with all CHAT and Care Coordination assessment results applicable to LTSS-specific Service Coordination to inform Service Planning and prevent the need for the administration of duplicative assessments.

The Contractor must maintain methods to maximize contacts with members in order to complete the Comprehensive Health Assessment required in this Section 4.6.

As part of the Contractor's annual Care Coordination Program plan and State review process, as described in Section 4.1, the Contractor must describe how the CHAT is used to develop and update, in a timely manner, the ICP for each member and how the CHAT information is disseminated to and used by the ICT. The Contractor must also describe its process for attempting to contact members and have them complete the CHAT, including provisions for members that cannot or do not want to be contacted or complete the CHAT. The Contractor must describe its plan and explain its rationale for reviewing, analyzing, and stratifying CHAT results to assign members to State-defined Care Coordination levels of service and identify members as part of subpopulations at greater risk for negative health outcomes that would benefit from the Contractor's targeted interventions and subpopulation-specific approaches described in Section 4.4.1. The Contractor must describe the mechanisms for communicating information to the ICT, provider network, members and/or their caregivers, and other Contractor personnel who may be involved with overseeing a member's plan of care, including mechanisms for requesting the member's consent when needed. The Contractor must explain how the Contractor uses CHAT results to improve the care coordination process.

The Contractor must describe how it will coordinate with providers and other parties, including the Contractor's companion D-SNP and other Medicare Advantage plans in order to reduce the assessments/assessment components identified as duplicative, administratively onerous, and/or overly burdensome to members and providers.

At a minimum, the Contractor must describe how it will incorporate LOC assessment results from the State's designated enrollment partner who performs NFLOC determinations into the CHAT. The Contractor's annual Care Coordination Plan must describe how results from the CHAT for "Dual Eligible – Aligned" members will be incorporated to the greatest extent possible with that member's aligned D-SNP Health Risk Assessment Tool (HRAT) to limit duplication in assessments and to eliminate unnecessary administrative processes.

The Contractor must maintain sufficient system and staff capacity to seamlessly link assessment information from both the CHAT and the D-SNP HRAT into a holistic composite of the care needs for members identified as "Dual Eligible – Aligned."

The Contractor shall have detailed writing protocols in place for how to operationalize the care decisions that flow from both the CHAT and HRAT with the appropriate Contractor and aligned D-SNP staff to support the work of the ICT.

The Contractor shall also ensure that there is sufficient staff capacity to understand and fluently communicate how the assessment linkage will better support both members and providers.

4.7 Reassessments

The Contractor will develop a process for reviewing and updating Individualized Care Plans with members, and with their consent, their family members and informal caregivers, on an as-needed basis, but no less often than annually. For members who qualify for Service Coordination and receive LTSS in the home or community, the member's Care Coordinator and Service Coordinator shall jointly conduct the CHAT reassessment onsite and send the applicable CHAT results to the entity or entities designated by the State for an updated NFLOC determination. For members residing in nursing facilities, the entity(ies) designated by the State shall conduct the annual LOC reassessment every 365 days and submit the results to the Contractor for incorporation into the member's record, after which the member's Care Coordinator and Service Coordinator shall meet jointly with the member to review and update the member's ICP and complete any other assessment components based on the member's needs. The ICT staff conducting reassessments shall ensure that the other ICT participants are updated and involved as necessary on reassessments.

In addition, members may move between stratified Care Coordination level of service groups over time as their needs change, therefore, the Contractor shall develop a protocol for re-evaluating members periodically to determine if their present care levels are adequate. The Contractor must at minimum re-screen and conduct a Comprehensive Health Assessment within one year of the initial assessment and within one year thereafter. Additionally, any member or provider can request that a member's Care Coordination level of service be reassessed for redetermination at any time.

In the Contractor's annual Care Coordination Program Plan, the Contractor shall establish a process for identifying and addressing the State-defined trigger events listed below. If a trigger event occurs, the Contractor must at a minimum reassess the member as expeditiously as possible in accordance with the circumstances and as clinically indicated by the member's health status and needs, but in no case more than five (5) business days after the occurrence of the following State-defined trigger events:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge.
- A change or loss of informal caregiver.
- A decline in social status (e.g. increased isolation/loneliness).
- A change in the home setting or environment if the change impacts one or more areas of health or functional status.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning
- As requested by the member or member's designee, caregiver, provider, the member's ICT, or the State.

When a complex medication regimen or behavior modifying medication or both are prescribed for a member, the ICT staff nurse or other appropriately licensed medical professional shall ensure the member is assessed and reassessed, as needed, but at least every six months for the desired responses and possible side effects of the medication, and understands the potential benefits and side effects of the medication and that all assessments results and follow-up have been completed and documented in the member record. If a complex medication regimen or behavior-modifying medication or both are prescribed, the ICT staff nurse or other appropriately licensed medical professional shall ensure that the Comprehensive Health Assessment includes the rationale for use and a detailed description of the behaviors which indicate the need for administration of the complex medication regime or behavior-modifying medication.

The Contractor shall also identify any triggers which would immediately move the member to a more intensive level of Care Coordination.

4.8 LTSS-specific Assessments

For members who qualify for Service Coordination, the Service Coordinator shall use the results of the member's CHAT and/or LOC assessment as the foundation of the strengths-based, LTSS-specific service planning process. Based on the member's choice and/or preferences, needs and risk factors, the Service Coordinator may conduct additional LTSS-specific assessments and reassessments. The member's Service Coordinator will appropriately facilitate this LTSS-specific assessment process through the application of person-centered discovery tools and practice to engage the member and the member's circle of support including their family members and informal caregiver, or another identified representative.

At a minimum, the Service Coordinator shall conduct the following assessments as part of the LTSS-specific assessment process:

- Monthly loneliness assessment, per the UCLA Three-Item Loneliness Scale, unless the member opts for less frequent check-ins according to Section 4.11
- Quarterly needs assessment, per a 90-day review tool developed or approved by the State
- Annual LOC reassessment, per the CHAT and conducted jointly with the member's Care Coordinator, for members receiving HCBS
- Annual informal caregiver assessment, as described in Section 4.8.2

Assessments can be conducted more often depending on the member's changing needs. Based on the outcomes of the assessments, a person-centered support plan ("Service Plan") is developed to address the member's LTSS needs and goals. The Service Plan must be integrated into the member's record and overall ICP. The Contractor shall inform members that they may request the LTSS-specific assessments be conducted in alternative modes, such as by phone or virtual visit, or settings, besides at the member's place of residence or service location. Upon request and to the extent possible, the Contractor shall coordinate with the member and/or the member's family member, informal caregiver, Supported Decision Maker(s), legal guardian, and/or Designated Representative to conduct assessments in a mode or setting convenient to the member and member's circle of support and reflective of the member's expressed preferences. The Contractor may outreach to members to inquire if the alternative assessment arrangements are the desired mode/setting for follow-up assessments and reassessments.

Unless otherwise assessed as part of the Contractor's Care Coordination processes or included in the member's CHAT results, the Contractor's LTSS-specific assessment process may also include, but is not limited to, the following explorations and assessments based on the member's specific health and social needs:

- An exploration with the member of the member's understanding of self-directed supports and any desire to self-manage the allowable portions of their care plan.
- An exploration with the member of the member's preferences in regard to privacy, services, caregivers, and daily routine, including, if appropriate, an evaluation of the member's need and interest in acquiring skills to perform activities of daily living to increase their capacity to live independently in the most integrated setting.
- An assessment of mental health and alcohol and other drug abuse (AODA) issues, including risk assessments of mental health and AODA status as indicated.
- An assessment of the member's overall cognition and evaluation of risk of memory impairment.
- An assessment of the availability and stability of natural supports and community supports for any part of the member's life. This shall include an assessment of what it will take to sustain, maintain and/or enhance the member's existing supports and how the services the member receives from such supports can best be coordinated with the services provided by the Contractor.

- An exploration with the member of the member's preferences and opportunities for community integration including opportunities to engage in community life, control personal resources, and receive services in the community.
- An exploration with the member of the member's preferred living situation and a risk assessment for the stability of housing and finances to sustain housing as indicated.
- An exploration with the member of the member's preferences for educational and vocational activities.
- An assessment of the member's understanding of their rights, the member's preferences for executing advance directives and whether the member has a guardian, protective order, durable power of attorney or activated power of attorney for health care.

4.8.1 Nursing Facility Assessments

As part of onsite assessment and care planning visit with members in nursing facilities a member's Service Coordinator shall conduct any needs assessment(s) deemed necessary by the Contractor, using tool(s) prior approved by the State and in accordance with protocols specified by the State. These assessments may include identification of targeted strategies related to improving overall wellness, health, functional, or quality of life outcomes (e.g., related to care coordination, pharmacy management, or a desire to transition to the home or community) or to increasing and/or maintaining functional abilities, including services covered by the Contractor that are beyond the scope of the nursing facility services benefit.

The Care Coordinator, in partnership with the Service Coordinator and LTC Ombudsman if applicable, shall ensure coordination of the member's physical health, behavioral health, and long-term care needs and shall assess at least annually the member's potential for an interest in transition to the community. See Section 4.12 for further transition requirements.

4.8.2 Informal Caregiver Assessments

Consistent with FSSA's goals to promote informal caregiver supports, the informal caregiver assessment will build upon skills and provide options for reducing stress and loneliness. The Service Coordinator, as applicable, shall conduct an informal caregiver assessment using a tool developed or determined by the State and in accordance with protocols specified by the State as part of its onsite visit with new members receiving LTSS and as part of its onsite intake visit for current members applying for LTSS. The consent of the member and informal caregiver is required.

At a minimum, the informal caregiver assessment shall include: (1) an overall assessment of the informal caregiver(s) providing services to the member to determine the willingness and ability of the informal caregiver(s) to contribute effectively to the needs of the member, including employment status and schedule, and other care-giving responsibilities; (2) an assessment of the informal caregiver's own health and well-being, including medical, behavioral, physical, social, or environmental limitations, such as but not limited to any food, utility, housing, and healthcare insecurities, as it relates to the informal caregiver's ability to support the member; (3) an assessment of the informal caregiver's level of stress related to caregiving responsibilities and any feelings of being overwhelmed; (4) identification of the informal caregiver's needs for training in knowledge and skills in assisting the person needing care; and (5) identification of any service and support needs for training in knowledge and skills to be better prepared for their care-giving role. Additionally, a Social Determinants of Health (SDOH) assessment for informal caregivers shall be included to identify needs such as current or potential lack of healthcare, food insecurity, utility instability, housing insecurity, transportation issues, and more.

The Contractor shall facilitate access for informal caregivers to social supports, paid supports, waiver services (such as, but not limited to, Structured Family Care, Informal Caregiver Coaching

and Behavior Management, and Self-Directed Attendant Care), and/or other non-traditional services that will help ameliorate assessed informal caregiver needs through direct referrals or an approved service plan, as applicable. The MCE must document how the Service Coordinator or other Contractor staff support the informal caregiver in connecting with referred resources, including the referral's location, contact information, Contractor outreach attempts, the date the information was shared with the informal caregiver, and the date of any follow-ups conducted to determine whether the informal caregiver has made contact with the referral and/or received services.

For informal caregivers who are assigned an Informal Caregiver Coach through the Informal Caregiver Coaching and Behavior Management waiver service, the Service Coordinator and the member's Care Coordination team shall incorporate the Informal Caregiver Coach into care/service planning activities as applicable and with the consent of the member. This includes, but is not limited to, engaging the informal caregiver and Informal Caregiver Coach in the development of a crisis management/emergency plan to support unplanned events that could impact the member and environment.

Additionally, the Care Coordinator, Service Coordinator, or Informal Caregiver Coach shall ensure that all identified informal caregivers have the 24/7 Nurse Helpline number (Section 3.14), information about 211, and the member's Service Coordinator's name and contact information.

The informal caregiver assessment shall be conducted upon initial enrollment to LTSS services, at least once every 365 days as part of the annual care plan review and reassessment process, upon a significant change in circumstances as defined in Section 4.7, when the informal caregiver changes, and as the Service Coordinator deems necessary with the consent of the member. For informal caregivers who receive the Informal Caregiver Coaching and Behavior Management waiver service, the Service Coordinator shall provide the informal caregiver's waiver service provider with timely results of the informal caregiver assessment and a record of any referrals to training, education, or resources that the Contractor has already provided to the informal caregiver, to reduce assessment and/or service duplication.

4.9 Individualized Care Plans

After the initial screening and Comprehensive Health Assessment, the Contractor shall assign members to a Care Coordination level of service, develop an Individualized Care Plan for each member, and facilitate and coordinate the holistic care of each member according to their needs. The Contractor shall utilize a strengths-based, person-centered care plan development process, which may be based on Person-Centered Thinking approaches from the Learning Community for Person Centered Practices, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, Charting the LifeCourse, or equivalent person-centered planning process.

"Care Plan" or "Individualized Care Plan (ICP)" refers to a specific plan of care developed according to a member's needs and assigned Care Coordination level of service. For members in Care Management, minimum requirements for Care Plans are described in Section 4.9.1. For members in Complex Case Management, Care Plan minimum requirements are described in Section 4.9.2.

The Contractor will use data from multiple sources in the development of each member's Care Plan, including, at minimum, claims data (where available), data collected during the initial screening, the Comprehensive Health Assessment, the D-SNP Heath Risk Assessment (if applicable), available medical records, Indiana Scheduled Prescription Electronic Collection & Tracking (INSPECT) and any other sources, to ensure that the care for members is adequately coordinated and appropriately managed. The Contractor will use the information to identify gaps in the member's current care planning approach, if the member is receiving other care and/or case management services at the time of enrollment, and communicate those findings to the member's PMP (if applicable) or other appropriate physician.

When developing ICPs, in conjunction with other qualified health care providers and the ICT (as applicable for members in Complex Case Management), the Contractor must ensure that there is a mechanism for members to drive and add to the ICP development. Such a mechanism should allow the member's family, informal caregivers, or others to participate in the ICP development process, if desired by the member. The ICP must reflect the cultural considerations of the member. In addition, the Care Plan development process must be conducted in plain language and be accessible to individuals with disabilities and individuals with limited English proficiency.

Services called for in the ICP will be coordinated by the Contractor's care coordination staff, in consultation with any other care managers already assigned to a member by another entity (i.e. Medicare, CMHC, county, provider, DCS, Bureau of Development Disability, or a treatment facility). For members in need of services provided by the LTC Ombudsman, the Contractor shall, as appropriate, invite an LTC Ombudsman staff person to participate in the care planning process in accordance with requirements set forth in Section 5.13. The Contractor will initiate and facilitate specific activities, interventions and protocols that lead to accomplishing the goals set forth in ICPs and shall be responsible for developing strategies to facilitate timely and secure communication and information sharing between providers, caregivers, and stakeholders.

ICPs will delineate a variety of "low touch" and "high touch" interventions and approaches ranging from member educational mailings, telephone contacts with members and providers, face-to-face visits, in-home visits, telehealth and telephonic outreach. Interventions may range from passive mailings for preventive care reminders to home visits by the care coordinator.

The Care Coordination Program Plan must include a description of how the Contractor determines how often to review and modify, as appropriate, the ICP as the member's health care needs change. The Care Coordination Program Plan must describe the Contractor's protocols to assess, plan, implement, reassess and evaluate members minimally including:

- Pain;
- Trouble sleeping;
- Anxiety/depression;
- Medications—poly-pharmacy, potentially inappropriate medications, and gaps in prescription refills;
- Skin;
- Bowel / bladder;
- Transitions;
- Health Maintenance – preventive care;
- Health Maintenance – prevention and wellness programs(s);
- Mobility;
- Nutrition;
- Advance care planning;
- Informal caregiver burden;
- Oral health;
- Preventing choking from inappropriate supervision with eating;
- Appropriate gait evaluation and falls prevention; and
- Sensory impairment – hearing and vision.

As part of the annual Care Coordination Program Plan, the Contractor must describe the process for developing ICPs at a minimum, including a detailed description of its chosen person-centered planning model or process, detail how the results of the initial Comprehensive Health Assessment and annual reassessment are included in ICPs. The Contractor must provide a detailed explanation of how its stratification results are incorporated into each member's ICP.

The Contractor's Care Coordination Program Plan must detail the personnel responsible for developing ICPs and engaging in the care planning process. The description of responsible staff must include roles and functions, professional requirements, and credentials necessary to perform these tasks in alignment with any staff qualifications and requirements set forth in Sections 4.13 and 4.14, as well as the mechanism for how the member or their informal caregiver/representative is involved in the care plan development.

4.9.1 Care Management – Individualized Care Plan Requirements

For members receiving the Care Management level of service, members must have a Care Management ICP developed and implemented within ninety (90) days of the member's MCE effective date. The member's Care Management ICP must reflect member needs. At a minimum, a member's ICP must contain documentation of a member's stratification level, the member's self-management goals and objectives, the member's personal healthcare preferences, the condition(s) for which the member should receive services and prevention and wellness programs(s), a description and schedule of services specifically tailored to the individual's needs to be delivered, the role of the member's informal caregiver (as applicable), identification of goals (met or not met), and contact information for the member's primary provider(s). Care Management ICPs must include the member's communication preferences and a schedule for distributing disease state related information, prevention, and appointment reminders as well as an annual review.

4.9.2 Complex Case Management – Individualized Care Plan Requirements

For members who qualify for Complex Case Management level of service, members must have a Complex Case Management ICP developed and implemented within sixty (60) days of the member's MCE effective date. Complex Case Management ICPs must include all elements required herein and in Section 4.2.2 Complex Case Management. The Complex Case Management ICP will identify the problems, barriers and issues related to the individual's health care needs. It will address goals, objectives and interventions to meeting the needs of the individual. Complex Case Management ICPs should anticipate volatile healthcare needs, including a need for immediate respite, medical advice or home health care. Complex Case Management ICPs should foresee possible crisis situations where immediate additional support is needed to prevent hospitalizations, long-term care or poor outcomes. The Contractor must have processes in place for how they would manage care for these members, including after business hours. Complex Case Management ICPs will delineate the frequency and mode of contacts with members, minimally monthly. See Section 4.11.2 on Minimum Member Contacts for additional requirements and exceptions.

ICPs will incorporate additional expertise as needed based on the person's health conditions, disabilities, pharmacy, and other urgent management needs. ICPs for Complex Case Management services must include a schedule for contact with the PMP (if applicable) and other providers. In crisis situations, contact with the member, PMP (if applicable) and other providers is expected to be immediate, frequent and intense and not less than monthly. The Contractor will assertively engage members and providers in the development of a Complex Case Management ICP to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

Complex Case Management care planning will include a focus on communication with the PMP (if applicable), other providers, and the member's natural support system, with emphasis on the responsibilities, actions, strengths, and goals of the member. The Complex Case Management ICP will identify strategies for best engaging the member in their own treatment.

For members needing Complex Case Management but who are unable or unwilling to actively engage, the Complex Case Management ICP will identify the problems, barriers and issues related to the individual's health care needs and recognize why, due to the person's condition or other reasons, the member cannot actively participate. In contact with the member, the member may not be actively engaged in coordinating with their medical team, however, the Contractor must engage the member in learning about the member's health condition and follow the Complex Case Management plan developed.

The Contractor will assist the member, the member's family and the member's physician(s) to develop a strengths-based ICP with specific objectives, goals and action protocols to meet identified needs. If the member's identified goals are not met at the time of ICP review, the Contractor's Care Coordination Program Plan must describe the process for reassessing the member's current ICP and determining the appropriate alternative actions.

The Complex Case Management ICP will include, at a minimum:

- The member's goals and objectives.
- The member's personal preferences.
- Member strengths as revealed through a person-centered approach.
- Social and environmental needs and supports.
- Functional and cognitive needs and supports.
- Behavioral health and substance use disorder needs and supports.
- Geriatric conditions (e.g., dementia, falls, malnutrition/weight loss, chronic pain, etc.).
- Active chronic problems, current non-chronic problems, cognitive needs, and problems that were previously controlled or classified as maintenance care but have been exacerbated by disease progression or other intervening conditions.
- Diagnosis(es).
- Accommodation needs (e.g., special appointment times, alternative formats) and auxiliary aids and services.
- Barriers to care (i.e. language, transportation, etc.).
- A description of services specifically tailored to the member's needs, and the scope, amount, duration and frequency of the services authorized, including any services that were authorized by the Contractor since the last ICP was finalized that need to be authorized moving forward.
- A schedule of preventive service needs or requirements.
- Prevention and wellness program action steps.
- A description of how the care coordinator will support the member in accessing services identified in the care plan.
- Referrals to community-based resources.
- Role of the member's caregivers, including the caregivers' activities/tasks, needs, and supports.

- Caregiver name, paid/unpaid status, contact information, and emergency contact status (as well as any POA, Guardianship, or legal authorities the caregiver might have).
- PMP (if applicable).
- Any care/case manager from a service delivery system, such as Structured Family Caregiving. for members with one.
- Assigned Care Coordinator, Service Coordinator (if applicable), and ICT participants.
- All designated points of contact and the member's authorizations of who may request and receive information about the member's services.
- An assessment of the member's understanding of their rights, the member's preferences for executing advance directives and whether the member has a guardian, durable power of attorney or activated power of attorney for health care.
- List of current medications, including prescription medications, over-the-counter medications, vitamins, and herbs, as applicable
- HCBS LTSS Service Plan or NF LTSS Service Plan when applicable
- A description of how the Contractor will coordinate with the member's Medicare, Veterans Benefits, Behavioral Health providers, and other healthcare insurance providers.
- Safety planning with the member including member-specific signals, including potentially non-verbal signals, indicating abuse neglect and/or exploitation

4.9.3 Individualized Care Plan Documentation and Distribution

The Contractor shall distribute a copy of the ICP to the member or the member's legal decision maker or designated representative. For self-directing members, the Contractor shall provide enough copies of the ICP for members and/or their legal decision makers to give to the member's providers. Distribution of the ICP shall occur at the initial ICP development and annually. The Contractor must ensure that the ICP is provided to the member's PMP (if applicable) or other significant providers.

The Contractor's Care Coordination Program Plan must describe how the ICP is documented and updated and where the documentation is maintained so it is accessible to the ICT, provider network, and members and/or their informal caregivers with the member's consent. The Care Coordination Program Plan must describe how the Contractor communicates ICP updates and modifications to members and/or their informal caregivers, the ICT, applicable network providers, other Contractor personnel and stakeholders, as necessary. The Contractor must describe how it plans to identify and involve informal caregivers (with the consent of the member), designated representatives, and legal guardians or persons holding a power of attorney for the member in care coordination activities including: care planning, receipt of notices, written consumer-facing materials, and ongoing communications with Contractor staff, including the member's Care Coordinator, Service Coordinator (if applicable), and other ICT participants.

4.10 Service Plan

The Contractor must comply with the federal requirements specified in 42 C.F.R. § 438.208(c)(3) and § 441.301(b) and (c) in developing the Service Plan, and the Contractor must provide the necessary level of support to ensure that the member directs the person-centered planning and ICT process to the maximum extent possible and is enabled to make informed choices and decisions.

For members who receive HCBS, the Service Coordinator is required to initiate a written Service Plan which addresses the member's LTSS and LTSS-related needs during the first visit with the member and must complete the Service Plan according to the timeframes described below in Section 4.10.5. The Service Coordinator shall review and update the Service Plan during each of the minimum member

contact points set forth in Section 4.11, Minimum Member Contact, or when there is a change in the member's condition or recommended services.

The person-centered service planning process must include but is not limited to the following:

1. Identifying, coordinating, and supporting members in gaining access to LTSS services and other covered services;
2. Identifying, coordinating, and assisting members in gaining access to noncovered medical, social, housing, educational, financial assistance, and other services and supports, including services provided by other community resources;
3. Informing members about available LTSS, required assessments, the person-centered Service Plan, service alternatives, service delivery options including participant-direction, risks, responsibilities;
4. Protecting a member's health, welfare, and safety including developing an emergency plan;
5. Facilitating member access to, locating, coordination, and monitoring needed services and supports;
6. Collecting additional necessary information including at a minimum, member preferences, strengths, and goals;
7. Reassessing a member's level of care annually;
8. Assisting in identifying and choosing willing and qualified providers;
9. Coordinating efforts and prompting the member to complete activities necessary to maintain LTSS eligibility;
10. Exploring coverage of services to address member-identified needs through Medicaid and other services such as Medicare, private insurance, VA services, and other informal unpaid supports;
11. Actively coordinating with other individuals and entities essential in the physical and social care delivered for the member to provide for seamless coordination;
12. Referral to all training, education and resources for informal caregivers as required in the Informal Caregiver Supports and Informal Caregiver Coaching section of the contract.

Service Plans should be based on the results of the functional assessment component of the CHAT and/or LOC assessment and any supplemental LTSS-specific assessments. If members have engaged in Care Coordination activities prior to meeting with their Service Coordinators, Service Coordinators must use any applicable information discovered during those Care Coordination activities, including member goals and/or preferences captured in Individualized Care Plans, to inform Service Plan development. Upon completion, Service Plans must be included in the member's record and incorporated into the member's ICP to support knowledge sharing and coordination across the ICT and Care and Service Coordination staff. The combined ICP and Service Plan shall be considered the member's CMS-required "Person-Centered Service Plan." The Contractor must have processes, practices, and system capabilities in place to increase efficiency and cross-collaboration, while reducing member burden in the assessment and care planning processes.

The member's combined ICP and Service Plan must encompass the following minimum components in order to fulfill CMS requirements for the Person-Centered Service Plan:

- Reflect that the setting in which the individual resides is chosen by the individual and meets the HCBS Settings Rule requirements of 42 C.F.R. §441.301(c)(4)-(5);
- Member's strengths and preferences;
- Member's specific and individualized assessed need(s), including clinical and support needs as identified through an assessment of functional need;

- Individually identified goals and desired outcomes;
- Services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural Supports are those relationships the member has with friends, family, and their community at large that enhance the quality and security of a member's life;
- Services for which the individual elects to self-direct, meeting the requirements of 42 CFR § 441.740;
- Risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed;
- The individual and/or entity responsible for monitoring the plan;

For members who reside in a provider-owned or controlled residential setting, which are settings where the beneficiary lives in a private residence owned by an unrelated caregiver (who is paid for providing HCBS to the individual), the Service Coordinator must document that any modification of the additional conditions, under 42 CFR § 441.710(a)(1)(vi)(A) through (D), is supported by a specific assessed need and justified in the member's Person-Centered Service Plan. For those members, the Person-Centered Service Plan must include the following, in addition to the minimum components listed above:

- Identify a specific and individualized assessed need for the modification;
- Documentation of the positive interventions and supports used prior to any modifications to the Person-Centered Service Plan;
- Documentation of any less intrusive methods of meeting the member's need(s) that have been tried but did not work;
- Descriptions of the condition(s) that are directly proportionate to the specific assessed need(s);
- Schedule of contacts and time limits for periodic reviews of the plan to determine if modification(s) are still necessary or can be terminated; and
- Assurance that the interventions and supports will cause no harm to the individual.

For members who reside in a provider-owned or controlled residential setting, the Service Coordinator must regularly collect and review data to measure the ongoing effectiveness of the modification. New data should be incorporated into the member's Person-Centered Service Plan. In addition, the Service Coordinator shall address any issues regarding provider compliance with the HCBS Settings Rule 42 CFR 441.301(c) within thirty (30) days of discovery.

For the written Service Plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR §435.905(b) and Section 5.4 of this Contract.

The Service Coordinator is responsible for the development and continuous modification (as needed based on health or social determinant of health changes) of the Service Plan to establish goals and priorities, comprehensively assess needs, evaluate available resources, and develop a plan of care; and to identify LTSS providers as well as other community partners to provide a combination of services and supports that best meet the needs and goals of the member and informal caregiver.

4.10.1 Assisted Living and Community Home Share Service Planning

For members receiving or planning to receive assisted living or community home share services, the members shall use their own income to pay for the cost of room and board for assisted living as it is not an allowable Medicaid expense. As part of the service planning process, the Service Coordinator will assist members and their representatives with understanding assisted living room

and board allowable rates under the 455 IAC 3-1-12. The Contractor shall not discourage the member from selecting assisted living or community home share services.

4.10.2 Nursing Facility Service Plans

The Service Coordinator will review a member's nursing facility care plan as part of coordination of care and provide input into the plan. The Service Coordinator will work with the nursing facility staff to determine the services that the member needs and the roles of who should be providing the services in the person-centered Service Planning process. The Service Coordinator will document the agreed upon roles and responsibilities. The Care Coordinator will be responsible for the coordination of Medicare benefits, Veterans benefits, behavioral health services, and other health coverage insurers and supports in conjunction with the nursing facility. A separate person-centered Service Plan does not have to be created as long as the NF care plan includes all appropriate services, goals for transitioning to the community (if desired by the member), quality of life goals, and how Medicare benefits, Veterans benefits, behavioral health services, and other health coverage will be coordinated.

For individuals with intellectual and developmental disabilities in a nursing facility, the Service Coordinator shall coordinate with the member's BDDS/OBRA service providers. The Service Coordinator shall regularly assess the member's specialized service needs including their need for self-advocacy support, and assist the member in connecting to and coordinating with BDDS/OBRA.

4.10.3 Service Plan Signatures

The Service Coordinator must obtain the electronic or written signatures of the member, member's designated representative (if applicable) and any others involved in the Service Planning process, indicating they participated in the process, they approve and understand the services outlined in the Service Plan as integrated into the ICP, and that services are adequate and appropriate to the member's needs. The Service Plan is not considered complete until all of the required signatures are received. A member may also sign indicating disapproval of the Service Plan if the member disagrees with the Service Plan. When this occurs, the Service Coordinator must provide the member with a denial notice within two (2) business days that includes their right to file a grievance and assist the member through the process as appropriate. A copy of the signed Service Plan is given to the member as well as all ICT participants. Service Coordinators must ensure that the member or guardian, providers, caregivers, and involved agencies have a copy of relevant documentation, including instructions on how to request an appeal.

The Contractor must provide members, members' designated representatives (if applicable), and providers involved in the Service Planning process with the option to electronically sign Service Plans. This includes providing access to the documents to be electronically signed for through a secure website or email system which includes a secure log-in, username, and unique password. All distribution of, and access to, signed materials must meet contract requirements in Section 6.10 Medical Records, including all applicable HIPAA and confidentiality requirements.

4.10.4 Service Plan Authorization

ICT staff will prepare service authorizations in accordance with the Contractor's approved service authorization policies and procedures and Section 7.8.1 Authorization of Services and Notices of Actions. For LTSS and HCBS services, the Contractor must seek State approval of its service authorization policies and procedures as part of its annual Care Coordination Program Plan. The policies and procedures must address how new and continuing authorizations of services are approved and denied.

The Contractor may choose to create or utilize decision-making guidelines or tasking tools for more frequently used items and/or services. If the Contractor wishes to utilize these guidelines or tools as part of the service authorization process, the guidelines and tools must be approved by the State. LTSS Services shall be authorized in a manner that reflects the member's ongoing need for such services and supports as determined through the CHAT and LTSS-specific assessment process and person-centered Service Plan.

The ICT staff shall give the member, as part of the Service Plan, a listing of the services and items that will be authorized by the Contractor. The list shall include at a minimum: the name of each service or item to be furnished; for each long-term care service, the units authorized; the frequency and duration of each service including the start and stop date; and for each service, the provider's name.

The State reserves the right to require the Contractor to submit Service Plans to the State for review and approval should such Service Plans represent a reduction in previously-approved hours or services above a State-determined threshold in a given period of time following the expiration of a member's continuity of care period.

4.10.5 Service Plan Timeline Requirements

For members who have a Level of Care change while enrolled in the plan and are determined NFLOC by the State-designated entity(ies) following a referral by or on behalf of a member, regardless of referral source, the Service Coordinator shall conduct a face-to-face visit with the member and complete and approve a Service Plan within five (5) business days of receiving the member's NFLOC determination notification from the State-designated entity. Within twenty (20) business days of receiving a notification from the State-designated entity that a member meets NFLOC, all HCBS included on a member's Service Plan, except Home Modification and Vehicle Modification, must be delivered or started.

At a minimum, the Contractor must successfully complete and approve ninety-five percent (95%) of all Service Plans within five (5) business days of notification to the Contractor from the State-designated entity that the members meet NFLOC.

At a minimum, the Contractor must ensure ninety-five percent (95%) of members have all the HCBS included on their Service Plans, excluding Home Modification and Vehicle Modification, delivered or started within twenty (20) business days of notification to the Contractor from the State-designated entity that the members meet NFLOC.

4.10.6 Service Plan Timeline Requirements – Program Implementation

For a member entering into the Contractor's plan who is determined NFLOC and receiving HCBS prior to implementation, within ninety (90) days of implementation, the member's Service Coordinator shall conduct an initial face-to-face visit (see Section 4.11), including any LTSS assessments (see Section 4.8), and may update the member's Service Plan If additional HCBS are needed. The Contractor must honor existing Service Plans for 180 days following implementation in alignment with Continuity of Care requirements (Section 3.22), unless the member requires an increase in HCBS.

If a member who is determined NFLOC and is receiving short-term nursing facility care on the MCE effective date, the member's Service Coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing services previously approved, but no more than ninety (90) days after implementation, to determine appropriate needs assessment and care planning activities.

If at any time before conducting the Comprehensive Health Assessment or LTSS assessments for a member entering into the Contractor's plan who is determined NFLOC and receiving HCBS

or short-term nursing facility care, the Contractor becomes aware of an increase in the member's needs, the member's Service Coordinator shall immediately conduct a functional needs assessment and update the member's Service Plan, and the Contractor shall ensure all new or adjusted HCBS included on the member's updated Service Plan, exclusive of Home Modification or Vehicle Modification, are delivered or started within ten (10) days of becoming aware of the change in the member's needs.

For a member entering into the Contractor's plan who resides in a nursing facility, at the time of enrollment with the Contractor, and has resided in a nursing facility for less than ninety (90) days, the member's Service Coordinator shall conduct a face-to-face in-facility visit within ninety (90) days of implementation and conduct a needs assessment as determined necessary by the Contractor (see Section 4.8.1). For a transitioning member who, at the time of implementation, has resided in a nursing facility for ninety (90) days or more, the member's Service Coordinator shall conduct a face-to-face in-facility visit within six (6) months of the member's enrollment with the Contractor and conduct a needs assessment as determined necessary by the Contractor (see Section 4.8.1).

4.10.7 Service Plan Monitoring

Service Coordinators will monitor and assess the quality and effectiveness of the member's Service Plan in a face-to-face contact every 90 days from the initial Service Plan activation. At least two of these face-to-face contacts per year will be in the member's home setting, consistent with the member's preference. When the initial Service Plan is activated, the Service Coordinator will either call or visit the individual within 15 days from initial Service Plan activation to ensure implementation of services.

The Service Coordinator must use the State-developed person-centered monitoring tool (PCMT) or a State-approved equivalent tool to support Indiana's compliance with Home and Community-Based Services (HCBS) regulations.

The State may review, question, and request revisions to LTSS members' Service Plans. The Contractor must provide the State with monthly aggregate reports on PCSP changes in a format specified by the State.

The Contractor must review the Service Plans of members that impacted the Contractor's ability to meet any LTSS-specific performance metrics as established in Section 7 Quality Improvement. The Contractor's initial review of such Service Plans and any interventions to improve the Contractor's performance outcomes in the associated measure should be noted in the Service Plan.

4.11 Minimum Member Contact

In addition to meeting the requirements for conducting assessments and reassessments (see Sections 4.6 - 4.8), the Contractor must conduct the following minimum member contact and outreach activities, as described below, according to a member's assigned Care Coordination level of service and where a member receives LTSS if the member is eligible for Service Coordination. Regardless of Care Coordination levels of service or Service Coordination eligibility, the Contractor must provide information, resources, and referrals as needed to all members, their families, and health care providers, as requested.

4.11.1 Care Management – Member Outreach and Contact

The Contractor shall establish policies and procedures that encourage all new members to have a preventive care visit within sixty (60) calendar days of the member's effective date of enrollment and ongoing member outreach as indicated for the entire population. Care Management services shall address each member's medical and health concerns, specific medical information, and

available community resources. Services will typically result in brief, short-term encounters. The Contractor will reach out to members and providers during the initial assessment period as well as on an ongoing basis, via phone, in person and through written notification, as well as using community health workers, to physically make contact when members cannot be reached or when Care Management via phone is not successful. Members in Care Management services will be provided with contact phone numbers at the Contractor to call with questions.

The Contractor must make every effort to contact members in Care Management by telephone. The Contractor may use Service Coordinators and community health workers to physically make contact when members cannot be reached via telephone within a predetermined, State-approved timeframe. Should such attempts fail, the Contractor shall develop a plan for how to reach members (including outreach to providers, repeated physical outreach, etc.). Materials should be delivered to the member in a manner in accordance with the member's preferences as outlined in Section 4.9.1, either through postal or electronic means directly to the consumer. Educational materials and telephonic contacts may utilize web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth-grade reading level and in accordance with all member communication requirements outlined in Section 5.7 and should be sent to members no less than quarterly. The Contractor shall consider utilizing the services of community health workers, as appropriate, to outreach to and provide information to those members participating in Care Management. The Contractor will be required to submit quarterly and annual data to document the number of persons receiving Care Management services, including the number of active and passive contacts made to the member.

For members who do not meet NFLOC or qualify for Complex Case Management, the Contractor must contact the member in person or by phone at least once every three (3) months, unless the member specifically requests to opt out or otherwise reduce the frequency of these contacts. The member's choice of contact frequency and mode must be documented in their ICP. The Contractor shall not encourage a member to request a reduction in contacts.

4.11.2 Complex Case Management – Member Outreach and Contact

Complex Case Management includes all of the services and benefits from Care Management. The Contractor may use Service Coordinators and community health workers, to physically make contact when members cannot be reached via telephone within a predetermined, State approved timeframe. Should such attempts fail, the Contractor shall develop a plan for how to reach members (including outreach to providers, repeated physical outreach, outreach to member's emergency contacts if known, etc.). All members in Complex Case Management must receive materials no less than monthly.

For Complex Case Management members who are also receiving Service Coordination, the member's Care Coordinator and Service Coordinator shall meet together with the member in-person at least once per year to conduct the LOC reassessment (applicable only to those receiving HCBS LTSS) and review and update the member's ICP and Service Plan. The Contractor must attempt to the greatest extent possible to include other ICT participants, especially those desired by the member, in this meeting.

All Complex Case Management members who are not NFLOC or receiving Service Coordination shall be contacted by their Care Coordinator at least monthly either in person or by telephone, unless the member specifically requests to opt out or otherwise reduce the frequency of these contacts. The member's choice of contact frequency and mode must be captured in their ICP. The Contractor shall not encourage a member to request a reduction in contacts by the Care Coordinator. For members who are NFLOC and receive the minimum Service Coordination contacts (Section 4.11.3 and 4.11.4), Care Coordinators may contact such members less frequently than monthly, but no less than once every three months or according to the members' preferences. The Care Coordinator shall be responsible for communicating and coordinating with the member's Service Coordinator between Care Coordination contacts regarding any updates to

member's status, needs, and/or preferences that are discovered during Service Coordination contacts.

4.11.3 Service Coordination – HCBS Minimum Contacts

For members who meet NFLOC and receive HCBS, the member's Service Coordinator shall monitor the member's person-centered Service Plan and conduct LTSS-specific assessments based on the member's needs and goals in a face-to-face contact every 90 days from initial Service Plan activation. The quarterly in-person assessments must also include a screening for abuse, neglect, and exploitation, and loneliness assessment according to the requirements in Section 5.13.

When the initial Service Plan is activated, the Service Coordinator must either call or visit the member within 15 days from initial Service Plan activation to ensure initial implementation of services.

Members shall be contacted by their Service Coordinator at least monthly either in person or by telephone, unless the member specifically requests to opt out or otherwise reduce the frequency of these monthly contacts. The Service Coordinator may also meet more frequently with the member when appropriate based on the member's needs and/or request. The member's choice of Service Coordinator contact frequency and mode must be captured in their person-centered Service Plan. The Contractor shall not encourage a member to request a reduction in contacts by the Service Coordinator.

The member/guardian/designated representative must be able to contact the member's Service Coordinator between the regularly scheduled visits to ask questions, discuss changes/needs and/or to request a meeting with the Service Coordinator. Service Coordinator must respond to the questions and/or requests made by the member/guardian/designated representative, within 48 hours (not including weekends and holidays).

4.11.4 Service Coordination – NF Minimum Contacts

For members who are NFLOC and long-term NF residents, Service Coordinators shall visit the members in person once per quarter to serve as advocates, coordinate appropriate outside services such as behavioral health services, assess the member's desire to transition, update the member's plan of care as needed, and promote advance care planning. The Service Coordinator shall communicate as needed with the member's Care Coordinator to address any changing or emerging medical needs of the member.

At a minimum, the member's Care Coordinator and Service Coordinator shall meet together with the member on-site at least once per year to conduct any needed reassessment/reassessment components, exclusive of the LOC assessment, review and update the member's plan of care, and evaluate the member's ability and/or desire to transition. The Contractor must attempt to the greatest extent possible to include other ICT participants, especially those desired by the member, in this meeting.

For members who have the ability and desire to discharge to HCBS, the Care Coordinator and Service Coordinator must coordinate to transition the member to a home or community-based setting in accordance with the requirements of Section 4.12 Transitions.

4.11.5 Documentation of Contact

The Service Coordinator is responsible for documenting evidence of any-and-all communications, which may include, but are not limited to: face-to-face meetings, phone calls, emails, electronic messages, and text messages. Communications may be with the member, informal caregivers, other staff, other professionals, as well as health care professionals that render services to the

members. Communication documentation must include the complete date and signature. Communication documentation must be stored electronically and be made available to the State upon request.

4.12 Transitions

Older adults or adults with disabilities moving between different health care settings are particularly vulnerable to receiving fragmented and unsafe care when transitions are poorly coordinated; thus, the Contractor must work actively to coordinate transitions, in accordance with the requirements herein.

A “transition” is the movement of a member from one care setting to another as the member’s health status changes. A “care setting” is the provider from whom or setting where a member receives health care and health-related services. In any setting, a designated practitioner has ongoing responsibility for a member’s medical care. Settings include, but are not limited to, home, home health care, acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility and outpatient/ ambulatory care/surgery centers. The Contractor shall be responsible for coordinating a member’s care throughout the transition process, which encompasses the period from identification of a member who is at risk for a care transition through the completion of a transition. This process includes planning and preparation for transitions and the follow-up care after transitions are completed. The Contractor shall facilitate the transition process even when a member is transitioning to a facility or service for which the Contractor is not the primary payor.

Care Coordinators must conduct an on-site visit within ten (10) days of a member’s change of care setting. For members who are transitioning, as defined in this Section, from the home or community into a nursing facility, the member’s Care Coordinator shall conduct an on-site visit within ten (10) days of transition to review and update the member’s plan of care and to establish a schedule for ongoing Care Coordinator and Service Coordinator contact with the member.

For members who are specifically transitioning, from an inpatient hospital stay (see Section 4.12.3) or institutional setting (see Section 4.12.2) back to the home or community, the member’s Care Coordinator must make an on-site visit to the member’s home or planned residence within three (3) days of transition. Section 4.12.2 covers additional nursing facility-to-community transition contact requirements.

4.12.1 Relocation Targeted Case Management

The Contractor must provide Relocation Targeted Case Management services in alignment with the process described in Section 4.12.2 for any Nursing Facility resident who is planning to return to the community and who requires support services to do so. This can be a part of Service Coordination services provided by the member’s Service Coordinator.

The Contractor’s annual Care Coordination Program Plan must identify and describe the different personnel on the member’s Transition Team responsible for coordinating the care transition process and for ensuring that follow-up services and appointments are scheduled and performed. At a minimum, the member’s Service Coordinator and Care Coordinator must participate in the member’s Transition Team. The Contractor shall have a process in place to notify members and/or their informal caregivers of the Transition Team personnel responsible for supporting them through transitions between any two care settings.

4.12.2 Nursing Facility-to-Community Transitions

The Contractor shall develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community. Such methods shall include, at a minimum:

a. Referrals, including but not limited to, treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;

b. Identification through the Care Coordination or Service Coordination process, including but not limited to: assessments, information gathered from nursing facility staff or review and assessment of members whose nursing facility level of care is ending and who appear to meet the at-risk level of care for HCBS.

c. Review and analysis of members identified by the State based on Minimum Data Set (MDS) data from nursing facilities.

Notwithstanding the nursing facility-to-community transition requirements set forth in this Section, the Contractor shall be responsible for monitoring all NF resident members' level of care eligibility and for completing the process to refer a member to a State-designated entity for nursing facility level of care assessment and determination or to transition a member to receive services in the home or community as appropriate, prior to the expiration of nursing facility level of care.

For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, the Contractor shall ensure that within fourteen (14) days of the referral a Service Coordinator conducts an in-facility visit with the member to determine the member's interest in and potential ability to transition to the community and provide orientation and information to the member regarding transition activities. The results of a Service Coordinator's in-facility visit must be conveyed to the member's Care Coordinator, and any resulting transition must be jointly coordinated by the member's Care Coordinator and Service Coordinator, with support provided as needed by other Transition Team participants.

If the Contractor becomes aware by means other than direct referral or the Care Coordination or Service Coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, the Contractor shall ensure that within thirty (30) days of such identification a Service Coordinator conducts an in-facility visit with the member to determine whether or not the member is interested in and the member's potential ability to pursue transition to the community. For trend monitoring and in accordance with FSSA's program goals of person-centeredness, the Service Coordinator shall notify the LTC Ombudsman of individuals who have expressed interest in transitioning back to the home or community and who have not been supported in doing so within ninety (90) days.

The member's Service Coordinator/Care Coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The Contractor shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

If the member wishes to pursue transition to the community, within fourteen (14) days of the initial visit or within fourteen (14) days of identification through the Care Coordination or Service Coordination process, the Service Coordinator shall conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by the State. This assessment shall include the identification of any barriers to a safe transition.

Any nursing facility to community transition shall be based on the individualized needs and preferences of the member. The Contractor shall not establish a minimum number of members on any Care Coordinator or Service Coordinator's caseload or a minimum number of residents of any facility that must be transitioned to the community. The Contractor shall ensure that Care Coordinators and Service Coordinators are screening members' potential for and interest in transition and when applicable, facilitating transition activities in a timely manner, but shall not require any Care Coordinator or Service Coordinator as a condition of employment to identify a minimum number of nursing facility residents for transition to the community. Nor shall the Contractor pay any Care Coordinator or Service Coordinator an incentive or bonus based on the number of persons transitioned from a nursing facility to the community, to ensure that transitions are appropriate and consistent with the needs and preferences of residents.

The Contractor must employ a sufficient number of dedicated staff members without caseloads, who specialize in supporting nursing facility-to-community transitions and who also meet the qualifications of a Service Coordinator specified in Section 4.14 to serve as Transition-dedicated Service Coordinators and support Transition Teams as needed across the State. The Contractor must engage additional expertise on the member's Transition Team, as needed, based on the person's medical and behavioral health conditions, disabilities, pharmacy, environmental needs, and other urgent management needs that require support throughout a transition Any such staff shall not be reported in the Care Coordinator or Service Coordinator ratios specified in Sections 4.15 and 4.16, and shall be responsible for proactively identifying members in NFs who are candidates to transition to the community and to further assist with the completion of the transition process. All transition activities identified as responsibilities of the Service Coordinator shall be completed by an individual who meets all of the requirements to be a Service Coordinator.

The Contractor shall conduct a Transition Assessment and develop a Transition Plan as necessary to facilitate the member's return to the community. Such assessment shall include a review of the circumstances which resulted in the nursing facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet their needs in the community such that transition back to HCBS is appropriate. The Contractor shall update the member's Service Plan, including any identified risks and corresponding mitigation strategies for HCBS members, as deemed necessary based on the member's needs and circumstances. The Service Coordinator must fully inform the member and member's family and/or informal caregiver, as applicable and with the consent of the member, of any identified risks to transition and engage the member in determining appropriate mitigation strategies in alignment with the member's expressed preferences and goals. The Service Plan shall include the frequency and type of Care Coordination and Service Coordinator contacts that exceed the minimum contacts required, to mitigate any additional risks associated with transition and shall address any special circumstances due to transition.

For those members whose transition assessment indicates that they are candidates for transition to the community, the Service Coordinator shall facilitate in coordination with the member's Care Coordinator the development of and complete a transition plan within fourteen (14) days of the member's transition assessment.

The Service Coordinator shall include other individuals such as the member's family and/or informal caregiver in the transition planning process if the member requests and/or approves, and such persons are willing and able to participate.

As part of transition planning, prior to the member's physical move to the community, the Service Coordinator shall visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other informal caregiver who will be residing with the member (as appropriate). The Service Coordinator shall include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including but not limited to an increase in face-to-face visits beyond the minimum required contacts.

The transition plan shall address all services necessary to safely transition the member to the community and include at a minimum, member needs related to housing, transportation, availability of informal caregivers, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.

The Contractor shall approve the transition plan and authorize any covered or cost effective alternative services included in the plan within ten (10) business days of completion of the plan. The transition plan shall be fully implemented within thirty (30) days from approval of the transition plan, except under extenuating circumstances which must be documented in writing.

The member's Service Coordinator shall also complete an updated Service Plan that meets all criteria for members receiving HCBS including but not limited to completing a Comprehensive Health Assessment or LTSS-specific assessments and completing and signing a risk agreement.

The member's Service Coordinator/Care Coordination Team shall monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition.

For members transitioning to a setting other than a community-based residential alternative setting, the Service Coordinator/Care Coordination Team shall upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new plan of care or Service Plan, as applicable, and shall take immediate action to resolve any service gaps.

For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first twenty-four (24) hours, the Service Coordinator shall visit the member in their residence. During the initial ninety (90) day post-transition period, the Service Coordinator shall conduct monthly face-to-face in-home visits to ensure that the Service Plan is being followed, that the Service Plan continues to meet the member's needs, and the member has successfully transitioned to the community.

For members transitioning to a community-based residential alternative setting or who will live with a relative or other informal caregiver, within the first twenty-four (24) hours the Service Coordinator shall contact the member and within seven (7) days after the member has transitioned to the community, the Service Coordinator shall visit the member in their new residence. During the initial ninety (90) day post-transition period, the Service Coordinator shall (1) at a minimum, contact the member by telephone each month to ensure that the Service Plan is being followed, that the Service Plan continues to meet the member's needs, and the member has successfully transitioned to the community; and (2) conduct additional face-to-face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met.

The Contractor shall monitor hospitalizations and nursing facility re-admission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.

The Contractor shall be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions that are not specifically assigned to the Service Coordinator.

The Contractor shall develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing by the State.

The Contractor shall implement policies and processes necessary to ensure that it is aware when a member is admitted to or discharged from a NF in order to facilitate care planning and as seamless a transition as possible, and to ensure timely notification to the State and other entities as appropriate.

a. The Contractor shall require NFs to notify the Contractor of all NF discharges, transfers between NFs, or elections of hospice services in a NF.
b. The Contractor shall, in a manner prescribed by the State notify: a) the State of all NF discharges and elections of hospice services in a NF and of all NF discharges and transfers between NFs; and b) receiving NFs of all applicable level of care information when a member is transferring between NFs.

c. The Contractor shall conduct a census as frequently as deemed necessary by the State to confirm the residency status of all MLTSS members

d. The Contractor shall take actions as necessary to address any discrepancies when a member is found to no longer be receiving LTC services, or is receiving services in a different service delivery setting, e.g., NF, HCBS, or hospice in a NF, including, as appropriate, disenrollment from MLTSS.

4.12.3 Inpatient Hospitalizations

Care Coordinators must contact members during an inpatient hospitalization, or as soon as practicable upon receiving notification of a member's inpatient behavioral health hospitalization.

In the event of an inpatient behavioral health hospitalization, the member's assigned Care Coordinator must work with the hospital discharge planner, behavioral health provider case manager and/or natural supports (i.e. family) to ensure that an outpatient follow-up appointment is scheduled to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge. The Contractor must ensure that lack of transportation is not a barrier to the member attending the outpatient follow-up appointment.

4.12.4 Housing Supports

The MCE must oversee pre-tenancy and transition services for housing, which prepare and support the member's move to housing in an integrated setting. This could include assistance to obtain and retain housing, activities to foster independence, and assistance in developing community resources to support successful tenancy and maintain residency in the community. At a minimum, the Contractor must provide a Housing Coordinator for assisting members and Service Coordinators to support transition or post-transition activities including, but not limited to, requests and referrals, assistance with eligibility documentation and verification, transition wait times, transition barriers and special needs/accommodations, rent amount, monthly income amounts, location of housing options chosen, and counties chosen for transition.

4.12.5 Member Information and Care Plan Transfer

The Contractor must ensure that elements of the member's ICP are transferred between health care settings when the member experiences a transition in care. The Contractor's annual Care Coordination Program Plan must describe the steps that take place before, during and after a transition in care has occurred for this process.

Members and/or their caregivers need access to members' personal health information in order to communicate about care with healthcare providers in other health care settings and/or health specialists outside their primary care network. The Contractor's Care Coordination Program must describe the process for ensuring that members and/or their caregivers have access to and can adequately use personal health information to coordinate care for the member.

4.12.6 Transitions and Discharge Planning due to Provider Facility Closures and License Termination

For this section, facilities are defined as skilled nursing, assisted living, adult day and residential homes. Provider notices regarding facility closure or license termination shall comply with state and federal requirements. The Contractor shall follow the requirements for disenrollment of a provider and notification to the State in Section 6.6 of this contract.

In the event the Contractor is notified of a provider facility closure or license termination, the Contractor shall inform the State's Office of Medicaid Policy and Planning's compliance and provider services departments within two business days. Upon notification, the Contractor shall

collaborate with the Office of the Long-Term Care Ombudsman and local ombudsmen to ensure all member transfer and discharge rights are upheld. The Contractor's Care or Service Coordination staff will meet in person with facility staff and each member residing in the facility planning to close, to initiate person-centered discharge planning within seven (7) calendar days (i.e., one week) of receipt of notice of the closure. The Contractor's Care or Service Coordination staff shall collaborate with the facility and the Office of the LTC Ombudsman and local ombudsmen to ensure the facility allows at least thirty (30) days for the member's transfer out of the facility. Fewer than thirty (30) days is permissible only if the member or authorized representative agree with the transfer and all aspects of continuity of care are in place. Information and the communication of transfer options shall be based on the member's person-centered care plan and current medical and psychosocial condition. The information shall be communicated in person and in writing to the member. The Contractor shall ensure continuity of care for the member upon transfer.

4.13 Care Coordinator Requirements

Care Coordinators must meet requirements as described in the Key Staff.

4.13.1 Care Coordinator Assignment

For all members regardless of their assigned Care Coordination level of service, the Contractor may consider such factors (to the extent they are known) as current member relationships, prior care coordinator, the person assigned to the member for care management in the Contractor's aligned D-SNP, specific medical needs, physical disabilities of the member, language needs, cultural compatibility, area of residence, and access to transportation when assigning the member a Care Coordinator. Upon assignment the Contractor must notify the member by telephone and in writing of their Care Coordinator's name, location and office telephone number. The Contractor may contact a new member prior to the commencement of their MLTSS program enrollment, so that new member does not go without a Care Coordinator for a period of time after Enrollment begins or after assessment of needs for LTSS.

The Contractor must also have a process for how members can request and, if available, be offered a different Care Coordinator according to the member's preferences and language/cultural needs. Such availability may take into consideration the Contractor's need to efficiently deliver Care Coordination in accordance with requirements specified herein, including for example, the assignment of a single Care Coordinator to members receiving nursing facility or community-based residential alternative services from a particular provider or the assignment of a Care Coordinator based on aligned D-SNP administrative efficiencies. These processes should be described in the Care Coordination Program description required as part of the annual Care Coordination Program review process, described in Section 4.1.

4.13.2 Learning Community for Person Centered Practices Training

All Care Coordinators must complete "Person Centered Thinking Training" through The Learning Community for Person Centered Practices ("Learning Community") or a Learning Community certified trainer within twelve (12) months of [MLTSS Program Name] implementation. Care Coordinators hired after the first twelve (12) months of [MLTSS Program Name] implementation must complete the required Learning Community training prior to serving [MLTSS Program Name] members.

Within six (6) months of [MLTSS Program Name] implementation, the Contractor must employ a minimum of two (2) staff who are certified through the Learning Community's train-the-trainer program to be able to provide training to the Contractor's Care Coordinator and Service Coordinator staff on an ongoing basis throughout the Contract period.

4.13.3 Care Coordinator Training Requirements

In addition to the required Learning Community training (see Section 4.13.2), the Contractor must provide orientation and training to newly hired Care Coordinators in a minimum of the following areas:

- Medicaid;
- Quality assurance;
- Quality improvement;
- An overview of the MLTSS program;
- The continuum of LTSS services, including available service delivery options, placement settings and service restrictions/limitations;
- Assessment processes, person-centered care planning, and care plan development and updates and population specific training relevant to the populations enrolled in the [MLTSS Program Name]; including training on applicable tools and protocols;
- Member rights and responsibilities;
- The federal regulations for the Security and Privacy of Protected Health Information found at 45 CFR Part 164 (HIPAA) and for the Confidentiality of Substance Use Disorder Patient Records found at 42 CFR Part 2;
- Self-direction of health care tasks;
- Coordination of care for dual eligible members;
- Critical incident reporting;
- Cultural competency performed or created in conjunction with disability and aging led organizations;
- Housing and employment services;
- Responsibilities related to recognizing, screening, monitoring for, and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect, self-neglect, and/or exploitation as defined in 455 IAC. 2-4-2; 455 IAC. 1-2-2(g-h) and in alignment with [MLTSS Program Name] requirements in Section 5.13;
- Individualized Care Plan documentation standards;
- End of life person centered planning, Advance Directives, including training in Physician (or Medical) Orders for Life-Sustaining Treatment (POLST or MOLST) or Physician Orders for Scope of Treatment (POST), and services and supports including covered services and how to access those services within the Contractor’s network;
- Information on the beneficiary support system, including but not limited to how to obtain assistance with choice counseling, filing grievances, complaints, or appeals, finding the status of a complaint or appeal, and resolving issues related to rights and responsibilities;
- Conducting a home visit and use of monitoring checklists and/or tools;
- Engaging and supporting informal caregivers;
- Population health;
- Behavioral health information, including identification of member’s behavioral health needs, covered behavioral health services, how to access those services within the Contractor’s network, the requirements for initial and quarterly behavioral health consultations, processes for making referrals for SMI determinations, and standards for the provision of services for members determined to have an SMI;

- Management of critical transitions (including hospital discharge planning), Nursing facility to community transitions, including training on tools and protocols and the Pre-Admission Screening and Resident Review (PASRR) process;
- Hearing and appeals;
- The 4Ms (Mentation, Mobility, Medications, and What Matters) of Age Friendly Health Systems;

In addition to orientation and training requirements listed above, all Care Coordinators shall be provided with regular ongoing training on topics relevant to the population(s) served. Care Coordinators must receive refresher training for areas found deficient through the Contractor's internal monitoring process.

The Contractor must conduct initial and annual training for its employed and contracted staff according to the requirements in Section 4.13, 4.14, and 2.4.5. The Contractor's Care Coordination Program Plan must describe the training strategies and content, as well as the methodology the Contractor uses to document and maintain training records as evidence that both Care Coordinator and Service Coordinator staff have completed required training. Contracted staff do not include physicians or other providers that the organization contracts with as part of the provider network. Documentation must include a complete description of the types of trainings and specific examples of slides or training materials. Descriptions may also include but are not limited to the results of competency testing. If the training plan is not currently operational, the Contractor's Care Coordination Program Plan must provide a complete description of the plan's training contents.

4.14 Service Coordinator Requirements

Service Coordinators must meet requirements as described in the Key Staff Section 2.4.

4.14.1 Service Coordinator Selection

The Contractor must offer eligible members a choice of Service Coordinator or Service Coordination entity from amongst those employed by or under contract with the Contractor. In the event the member chooses another Service Coordinator or Service Coordination entity, the current Service Coordinator is to fully assist the individual in their transition to the new agency or individual Service Coordinator of choice.

The Contractor's Care Coordination Program Plan must include written policies and procedures for allowing members to select or be assigned to a new Service Coordinator whenever requested by the member, when a Service Coordinator is terminated from the Contractor's Network, or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding.

4.14.2 Learning Community for Person-Centered Practices Training

All Service Coordinators must complete "Person-Centered Thinking Training" through The Learning Community for Person-Centered Practices ("Learning Community") or a Learning Community certified trainer prior within ninety (90) days of their hire date. A Service Coordinator Supervisor must supervise or review Service Plans developed by Service Coordinators who serve [MLTSS Program Name] members prior to completing "Person Centered Thinking Training."

4.14.3 Service Coordinator Training Requirements

In addition to the required Learning Community training (see Section 4.14.2), the Contractor must provide orientation and training to newly hired Service Coordinators in a minimum of the following areas:

- Medicaid;
- Service Definitions included in Indiana's 1915(c) Waiver;
- Case Management;
- Level of care (general and skilled needs);
- Level of Care activities of daily living;
- Quality assurance;
- Quality improvement;
- An overview of the MLTSS program;
- The continuum of LTSS services, including available service delivery options, placement settings and service restrictions/limitations;
- Assessment processes, person-centered care planning, and care plan development and updates and population specific training relevant to the populations enrolled in the [MLTSS Program Name]; including training on applicable tools and protocols;
- Member rights and responsibilities;
- The federal regulations for the Security and Privacy of Protected Health Information found at 45 CFR Part 164 (HIPAA) and for the Confidentiality of Substance Use Disorder Patient Records found at 42 CFR Part 2;
- Consumer direction of eligible HCBS;
- Self-direction of health care tasks;
- Coordination of care for dual eligible members;
- How to immediately identify and address service gaps;
- Critical incident reporting;
- Cultural competency, performed or created in conjunction with disability and aging led organizations;
- Housing and employment services;
- Supportive technologies which help members stay at home or maintain independence;
- Responsibilities related to recognizing, screening, monitoring for, and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect, self-neglect, and/or exploitation as defined in 455 IAC. 2-4-2; 455 IAC. 1-2-2(g-h) and in alignment with [MLTSS Program Name] requirements in Section 5.13;
- The principle of most integrated, least restrictive settings for member placement;
- The HCBS Settings Rule 42 CFR 441.301(c)
- Development and implementation of back-up plans in the event of informal caregiver inability;
- Risk assessment and incorporating identified risk and risk mitigation strategies into the member's plan of care;

- End of life person centered planning, Advance Directives, services and supports including covered services and how to access those services within the Contractor's network;
- Information on the beneficiary support system, including but not limited to how to obtain assistance with choice counseling, filing grievances, complaints, or appeals, finding the status of a complaint or appeal, and resolving issues related to rights and responsibilities;
- Conducting a home visit and use of monitoring checklists and/or tools;
- Engaging and supporting informal caregivers;
- Population health;
- Behavioral health information, including identification of member's behavioral health needs, covered behavioral health services, how to access those services within the Contractor's network, the requirements for initial and quarterly behavioral health consultations, processes for making referrals for SMI determinations, and standards for the provision of services for members determined to have an SMI;
- Management of critical transitions (including hospital discharge planning), Nursing facility to community transitions, including training on tools and protocols and the Pre-Admission Screening and Resident Review (PASRR) process; and
- Hearing and appeals.

In addition to orientation and training requirements listed above, all Service Coordinators shall be provided with regular ongoing training on topics relevant to the population(s) served. Service Coordinators must receive refresher training for areas found deficient through the Contractor's internal monitoring process.

4.14.4 Service Coordinator Subcontracting

The Contractor shall subcontract for Service Coordination with current Aged & Disabled waiver care management entities during the first two years of the program as required in Section 4.1. The Contractor's Care Coordination Program Plan shall describe the development of these relationships, methods for communication, and accountability, quality oversight, and performance standards.

Only Service Coordinators operating on behalf of current Aged and Disabled waiver care management entities will count towards the 50% requirement. Any Contractor employees who have previously been employed by a care management entity do not count towards meeting the 50% standard. The Contractor may exceed the 50% threshold and may partner will multiple waiver care management entities to meet the requirement.

The State reserves the right to request ad-hoc reports and audit the Contractor's compliance with the 50% threshold at any time.

If after the first two years of the program, the Contractor determines it will ramp down or cease subcontracting with care management entities for Service Coordination, it shall provide a transition plan to the State at least 90 days in advance of the expected transition date to ensure members experience no gaps in Service Coordination. The Contractor shall not commence any ramp down or transition without prior State approval.

4.15 Care Coordinator Caseload Requirements

The Contractor's Care Coordinators will work in partnership with a member's Service Coordinator (if applicable), ICT, providers, and other caregivers to ensure that the member's overall care is coordinated and well managed. Each member will have an assigned Care Coordinator, and each of the Contractor's Care Coordinators may be assigned to multiple members. However, for members who are assigned to Complex Case Management according to the criteria in Section 4.2.2, the Care Coordinator-to-member ratio will not exceed 1:50, unless otherwise approved in writing by the State.

For member's residing in nursing facilities, the member's Care Coordinator shall serve as the main point-of-contact for nursing facilities regarding the member's care. The Contractor shall assign or designate at least one Care Coordinator to each nursing facility within the Contractor's network to serve institutional LTSS members and support streamlined communication and ongoing collaboration with facilities and facility-based resources.

A single individual may serve as both a member's Care Coordinator and Service Coordinator, if that individual meets the requirements for both roles as described in Sections 4.13 and 4.14. Should a single individual serve both Care Coordinator and Service Coordinator functions, that individual may not have a caseload exceeding fifty (50) unique members at any given time.

4.16 Service Coordinator Caseload Requirements

Each member who is determined NFLOC and receiving LTSS will have a Service Coordinator, in addition to an assigned Care Coordinator, and each of the Contractor's Service Coordinators may serve multiple members receiving LTSS.

4.16.1 Service Coordinator for NF Residents

The State encourages the Contractor to assign or designate at least one Service Coordinator to each nursing facility within the Contractor's network to serve institutional LTSS members and support ongoing collaboration with facilities and facility-based resources.

4.16.2 Service Coordinator Mixed Caseload Requirements

The average weighted Service Coordinator-to-member staffing ratio shall be no more than 1:100. Such average shall be derived by dividing the total number of full-time equivalent Service Coordinators by the total weighted value of members as delineated below.

The required maximum caseload for any individual Service Coordinator is a weighted value of no more than one hundred (100) members. The Contractor shall use the following methodology to calculate weighted Service Coordinator-to-member staffing ratios and caseloads:

- Each member who is determined to be NFLOC and has resided in a nursing facility for ninety (90) or more days shall be factored into the weighted Service Coordinator-to-member staffing ratio and weighted caseload calculations utilizing an acuity level of one (1), EXCEPT that:
    - Upon completion of a Transition Assessment (see Section 4.12.2), which indicates that a member is a candidate for transition to the community, such member shall be factored into the weighted caseload and staffing ratio calculations using an acuity level of two (2) until such time as the member is transitioned to the home or community or the member is no longer a candidate for transition.
- Each member who is determined to be NFLOC and receives LTSS in the home or community shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two (2).

If a mixed caseload is assigned, there can be no more than a weighted value of 100. The following formula is to be used in determining a Service Coordinator's mixed caseload:

(# of members in an institutional setting x 1.0) + (# of members identified as candidates for transition to the community x 2) + (# of members in an HCBS setting x 2) = 100 or Less

4.17 Interdisciplinary Care Team (ICT)

Under [MLTSS Program Name], the Contractor must use an ICT for the coordination of care for each member assigned to the Complex Case Management level of service. Where there is no conflict with [MLTSS Program Name] requirements in this Section, the Contractor shall use its companion D-SNP's CMS-approved MOC to provide ICT services. In cases where the Contractor's companion D-SNP's CMS-approved MOC does not meet Indiana [MLTSS Program Name] standards, the Contractor shall modify or adapt its companion D-SNP's CMS-approved MOC approaches to meet the requirements in Section 4.17 when delivering ICT services to [MLTSS Program Name] members who are assigned to Complex Case Management.

4.17.1 ICT Participants

For [MLTSS Program Name] members who qualify for an ICT, the Contractor must use an ICT skilled in nursing, social work and behavioral health, with knowledge of local community resources to implement protocol-driven care modules for members. This will include action steps to be followed when needs are identified. The ICT is responsible for the initial assessment and on-going re-assessment and evaluation of qualified members. At a minimum, a member's ICT must include the following:

1. The member
2. The member's Care Coordinator
3. The member's Service Coordinator (applicable only for members who are NFLOC and receive LTSS)
4. Any member-selected supports, including informal caregivers

The Contractor must incorporate additional expertise as needed based on the person's medical and behavioral health conditions, disabilities, pharmacy, environmental needs, and other urgent management needs. Additional resources and ICT participants may include, but are not limited to:

- The member's PMP if requested by the member or the facility's medical director as applicable
- Participants from the member's facility's care team if the member resides in a facility
- Physician(s), Nurse Practitioner and/or Physician Assistant's involved in the care of the member or who have relevant expertise to assist the member and ICT
- Physical therapists
- Occupational therapists
- Speech/language therapists
- Nutritionists or registered dieticians
- Pharmacists with polypharmacy or geriatric experience
- Behavioral health specialists

As part of the Contractor's annual Care Coordination Program Plan, as described in Section 4.1, the Contractor must describe the composition of the ICT if the Contractor chooses to include other ICT participants as part of the minimum composition of every ICT or assign additional resources for specific or targeted member groups, including how the Contractor determines ICT membership in alignment with a person-centered approach and the roles and responsibilities of each ICT participant. The description must specify how the expertise, training, and capabilities of

the ICT participants align with the identified clinical and social needs of the [MLTSS Program Name] members. The description must also include how the Contractor verifies ICT participant training and expertise in an applicable specialty for the targeted members.

In the annual Care Coordination Program Plan, the Contractor must:

- Explain how the Contractor facilitates the participation of members, their caregivers, and member-selected natural supports as participants of the ICT in alignment with a person-centered process.
- Describe how the member's CHAT, ICP, and the member's expressed goals are used to determine the composition of the ICT; including where additional ICT participants are needed to meet the unique needs of a member.
- Explain how the ICT uses health care outcomes to evaluate processes established to manage changes or adjustments to the member's health care needs on a continuous basis.

4.17.2 ICT Participant Roles and Responsibilities

The member's Care Coordinator shall serve as the member's primary point of contact for the ICT and shall be responsible for coordinating with the member, ICT participants, and outside resources to ensure the member's needs are met. For members receiving LTSS, their Service Coordinator must be included on their ICT and will report to the member's Care Coordinator. Service Coordinators shall be responsible for ensuring the member's LTSS-specific Service Plan is incorporated into the ICP and any LTSS-specific updates are reflected in ICP on an ongoing basis. In accordance with Section 2.21, the Contractor shall designate the member's Care Coordinator as the single point of coordination on the member's Integrated Care Team (ICT) for its dually-eligible members enrolled in its aligned D-SNP to coordinate member care across Medicaid and Medicare.

As part of the annual Care Coordination Program review process, the Contractor must describe how it uses care coordinators, service coordinators (as applicable), and other resources who play critical roles in providing an effective interdisciplinary care process; how service coordinators will be integrated into ICTs for members who are LTSS recipients; and how members and/or their caregivers are included in the process, are provided with needed resources and how the organization facilitates access for members to ICT participants.

4.17.3 ICT Communication Plan

The Contractor will engage the member's PMP (if applicable), facility medical director or other significant practitioner(s) in Care Coordination activities through ongoing, direct interaction between the practitioner and the ICT. For members who are assigned to the Complex Case Management level of service, this involvement will include semi-annual care conferences based on the member's assessment and evaluation. The Contractor will offer to travel to the practitioner's office to conduct the care conference, or conduct it via teleconference, at the practitioner's option. A minimum of two (2) weeks prior to each care conference, the Contractor will solicit input from the member's practitioner for updating the Individualized Care Plan and consideration for appropriate stratification. Contractors shall reimburse practitioners for their time at these care conferences.

As part of its annual Care Coordination Program Plan, as described in Section 4.1, the Contractor must describe the Contractor's communication plan for promoting regular exchange of member information within the ICT and applicable practitioners, providers, and stakeholders. The Contractor's Care Coordination Program must show:

a. Clear evidence of an established communication plan that is overseen by Contractor personnel who are knowledgeable and connected to multiple facets of the Contractor's Care Coordination Program.

b. How the Contractor maintains effective and ongoing communication among Contractor personnel, the ICT, members and/or their caregivers, community organizations and other stakeholders.

c. The types of evidence used to verify that communications have taken place (e.g., written ICT meeting minutes, documentation in the ICP).

d. How communication is conducted with members who have hearing impairments, language barriers and cognitive deficiencies.

e. How the Contractor will engage with and promote the participation of a member's primary care physician in the member's ICT,

f. How the ICT will communicate, collaborate, and/or cooperate with legal assistance resources, the LTC Ombudsman, and Adult Protective Services.

4.18 Care Coordination and Service Coordination Performance and Monitoring

4.18.1 Contractor Collaboration

The Contractor shall collaborate with the State, and other contractors to promote Care Coordination and Service Coordination efforts and measure its effectiveness through an intervention on a mutually agreed upon topic by the State, the Contractor, and the other contractors.

4.18.2 Contractor Cooperation

The Contractor will cooperate with any research or evaluation of Care Coordination and/or Service Coordination conducted by the State, CMS or their contractors.

4.18.3 Care Plan Audits and Service Plan Reporting

The Contractor shall audit a sample of Individualized Care Plans, which include Service Plans (as applicable), for its members. The sample must follow appropriate sampling methodology. The sampling methodology shall account for including a mix of Service Plans developed by Contractor staff and by subcontract case management entities. The Contractor must use a protocol submitted to and approved by the State. A summary of the audit results shall be submitted in a form and manner determined by the State. The Contractor must be able to submit member-level data to the State to ensure the integrity of the Care Plan audits. These audits are broader than assurances found in section 7.1.13 and incident reporting in 7.1.14 but should also include the requirements found in these sections.

The Contractor shall cooperate with collecting and reporting data needed to comply with the 1915(c) Waiver performance measures on service planning. The Contractor must comply with the applicable requirements of CMS' "Quality Framework," for HCBS, including those found in the CMS "Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers" published in March 2014. The Contractor must retain Service Plans for a minimum of five (5) years, during which time they must be made available electronically to the State upon request.

4.18.4 Care Coordination/Service Coordination Reviews

The Contractor shall conduct reviews of delegated entities that the Contractor owns or with which the Contractor has a subcontract to provided Care Coordination and/or Service Coordination for

members covered under this Contract including subcontracts with Aged & Disabled waiver care management entities.

4.18.4.1 Reviews must include but are not limited to Care Plan audits as specified under Section 4.18.3. The review must address the delegate's compliance with subcontract requirements such as those described in the Section 2.9.

4.18.4.2. Written audit reports of each reviewed delegate must be submitted to the State by a date determined by the State of each Contract Year using the Care Coordination Review Reporting template developed jointly by the State and the Contractor. The written reports must include a description of the organizational, service delivery, and case management structures, and the risk sharing arrangement between the Contractor and each delegate that is reviewed. In addition, the written reports must include the process used by the Contractor to conduct the review, any deficiencies and/or concerns raised during the review, and any corrective actions taken by either the Contractor or by the delegate to address deficiencies and/or concerns raised during the review.

4.18.4.3. Audit reports shall review that Care Coordination processes are performed in a comprehensive, holistic, person-centered manner in accordance with best practices and evidence-based guidelines. The Contractor's audit reports shall include:

a. Appropriate risk assessments are performed on a timely basis;
b. Members and legal decision makers when appropriate participate in the preparation of the care plan;
c. Care plans address all members' assessed needs (including health and safety risk factors) and outcomes;
d. Care plans are updated and revised in accordance with the applicable standards for timeliness and when warranted by changes in the members' needs and outcomes;
e. Services are delivered in accordance with the type, scope, amount, and frequency specified in the member-centered plan;
f. Members are afforded choice among covered services and providers; and
g. Overall member risk, including risk for different stratification levels identified through assessment; appropriate interventions are documented on the care plan to mitigate risk while balancing member's overall quality of life and individual choice.

4.18.4.4. The Contractor will work with the State and other Contractors on methods for coordinating Care Coordination Program reviews among Contractors and other delegated entities, including development of joint review protocols and summary reporting formats. The Contractor will also work with the State to develop a method to identify delegates with consistently high performance at review and to develop recommendations for a process that may allow for these identified delegates to be reviewed on a schedule other than annually, and/or utilizing alternative review methods. Any process and/or method developed must continue to meet state and federal requirements for review of care plans and the purpose of the review.

4.18.5 Care Coordination Program Monitoring

The Contractor's annual Care Coordination Program Plan shall include a description of the Contractor's systematic method of monitoring its Care Coordination Program and methodology for assigning and monitoring Care Coordination and Service Coordination caseloads. The Care Coordination Plan shall also include an evaluation of the Contractor's Care Coordination Plan from the prior year, to include lessons learned and strategies for improvement.

The Contractor shall implement a systematic method of monitoring its Care Coordination Program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of member assessments/service authorizations (inter-rater reliability). The Contractor shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Contractor has taken to resolve identified issues. This information shall be submitted to the State on a quarterly basis as specified in Section 10 Performance Reporting and Incentives and the Reporting Manual.

4.18.5.1 Risk and Safety Performance Monitoring Mechanism

As part of the Contractor's annual Care Coordination Program Plan, the Contractor must describe its mechanism(s) to monitor, evaluate and improve its performance in the area of safety and risk issues. These mechanisms shall ensure that the Contractor offers individualized supports to facilitate a safe environment for each member in accordance with the requirements of Section 5.13 Procedures Regarding Potential Abuse, Neglect, and Exploitation (ANE) of Older Adults. The Contractor shall assure its performance is consistent with the understanding of the desired member outcomes and preferences. The Contractor shall include family members and other natural and community supports when addressing safety concerns per the member's preference.

4.18.5.2 Gap in Critical Services

The Contractor is responsible for establishing a network of contracted providers adequate to ensure that Critical Services are provided without gaps in care.

The term "Critical services" includes attendant care, personal care, homemaker, and respite care, and is inclusive of, but not limited to, tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities.

A Gap in Critical services is defined as the difference between the number of hours of Critical services approved in a member's service plan for a service and the number of hours of the Critical service that are actually delivered to the member.

The following situations are not considered gaps in Critical Services:

- The member is not available to receive the service when the provider/employee arrives at the member's home at the scheduled time;
- The member refuses the provider/employee when he/she arrives at the member's home at the scheduled time, unless the provider/employee's ability to accomplish the assigned duties is significantly impaired by the provider/employee's condition or state (for example, drug and/or alcohol intoxication);
- The member refuses services;
- The provider agency or service coordinator is able to execute the member's back-up or find an alternative provider/employee for the scheduled service at the scheduled time when the regular provider/employee becomes unavailable;
- The member and regular provider/employee agree in advance to reschedule all or part of a scheduled service; and/or
- The provider/employee refuses to go or return to an unsafe or threatening environment at the member's residence.

In those instances where an unforeseeable gap in Critical services occurs, the Contractor shall ensure that Critical services are provided within four hours of the report of the gap.

If the provider agency or Service Coordinator is able to contact the member or member representative before the scheduled service to advise him/her that the regular provider/employee will be unavailable, the member or member representative may choose to receive the service from a back-up substitute provider/employee, at an alternative time from the regular provider/employee or from an alternate provider/employee from the member's informal support system. The member or member representative has the final say in how (informal versus paid) and when care to replace a scheduled provider/employee who is unavailable will be delivered.

When the provider or the Contractor is notified of a gap in Critical services, the member or member representative must receive a response acknowledging the gap and providing a detailed explanation as to the reason for the gap, and the alternative plan being created to resolve the particular gap and any possible future gaps.

The Contractor shall implement policies and procedures to identify, correct, track, and report gaps in critical services. The Contractor's annual Care Coordination Program Plan must describe these policies and procedures for gaps in critical services.

5.0 Member Services

5.1 Marketing and Outreach

Limited marketing efforts will be permitted at the sole discretion of the State of Indiana. Marketing efforts shall be targeted to the general community in the State of Indiana in accordance with 42 CFR 438.104, and the requirements outlined in Section 5.7, the Contractor must submit requests for approval on marketing materials allowing the State of Indiana a minimum of thirty (30) calendar days to review and the Contractor must obtain State approval for all marketing materials prior to distribution. All marketing materials must be distributed to the Contractor's entire service area and shall comply with the information requirements delineated at 42 CFR 438.10. Such materials shall be in a manner and format that is easily understood and meet the general communication material requirements discussed further in Section 5.7. Marketing materials should include the requirements and benefits of the Contractor's health plan, as well as the Contractor's provider network.

The Contractor may market via digital, mail and mass media advertising such as digital media, radio, television and billboards. Community oriented marketing such as participation in community health fairs is encouraged. Tokens or gifts of nominal value may be distributed at such events to potential members, so long as the Contractor acts in compliance with all marketing provisions provided for in 42 CFR 438.104, and other federal and state regulations and guidance regarding inducements in the Medicare and Medicaid programs. Upon request by member(s) or potential member(s), marketing materials shall be available in the member's preferred language and/or format. The Contractor shall document the member's preferred language and/or format and deliver all future materials to the member in the preferred manner. The Contractor shall submit product naming and associated domains to FSSA for review and approval to minimize confusion for members and providers

The contractor shall not coerce a potential member or their legal representative into choosing a certain MCE. Marketing materials and plans shall be neutrally designed to reach a broad distribution of potential members across age and gender categories. The Contractor must conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. The Contractor must provide information to potentially eligible individuals who live in medically underserved rural areas of the State. Potential members may not be discriminated against on the basis of health status or need for health care services, or on any other basis inconsistent with state or federal law, including Section 1557 of the Affordable Care Act / 45 CFR 92.1.

The Contractor shall not conduct individual enrollee marketing activities. This prohibition includes, but is not limited to the following information and activities:

1. Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers.

2. Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques;

3. Offers of gifts or material or financial gain as incentives to enroll;

4. Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;

5. Direct solicitation of prospective enrollees;

6. Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

7. Assertions or statements (whether oral or written) that the enrollee must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;

8. Assertions or statements (whether written or oral) that the Contractor is endorsed by CMS, the federal or state government or similar entity;

9. Use of independent marketing agents in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions;

10. Seeking to influence enrollment in conjunction with the sale or offering of any private insurance;

11. Distributing marketing materials to select or partial service areas for which the Contractor is authorized to serve.

12. The Contractor shall not use the name of the Contractor's Indiana Medicaid MCE name in any form of general marketing without the State of Indiana's prior written approval; and

13. Any activity deemed contrary to the goals of the [MLTSS Program Name] by the State of Indiana.

5.2 Member Enrollment and Contractor Selection

[MLTSS Program Name] applicants have an opportunity to select an MCE on their application or by calling the Enrollment Broker within sixty (60) days of the coverage start. MCEs are expected to conduct marketing and outreach efforts to raise awareness of the [MLTSS Program Name] program and their product. The Enrollment Broker is available to assist members in choosing an MCE. Applicants who do not select an MCE on their application will be assigned to an MCE according to the State's assignment methodology after sixty (60) days. The Contractor's companion D-SNP must be exclusively aligned with its [MLTSS Program Name] Medicaid plan and will only be allowed to enroll dual eligible members who are also enrolled in its [MLTSS Program Name] Medicaid plan. Members enrolled in the Contractor's

[MLTSS Program Name] Medicaid plan who later become Medicare-eligible for the first time will be default enrolled into the Contractor's companion D-SNP.

The State reserves the right to amend the assignment logic and may incorporate HEDIS or other quality indicators into the assignment logic at a future date. Member assignment will not be available to any MCE who does not successfully complete readiness review. Default assignment will not be available for any plan that has an associated D-SNP that fails to meet the minimum Medicare Star rating of three (3) stars as defined in 42 CFR 422.252. Information about member enrollment and contractor selection shall be subject to the requirements as described in Section 5.4 Member Information, Education, and Outreach.

Members will have the opportunity to change their MCE at the following intervals:

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

Any Medicaid member may change their MCE for Just Cause. The "for cause" reasons are described in 42 CFR 438.56(d)(2)(iv). Determination as to whether a member has met one of these reasons is solely the determination of the Enrollment Broker and FSSA. The reasons include, but not limited to, the following:

- Receiving poor quality of care;
- Failure to provide covered services;
- Failure of the Contractor to comply with established standards of medical care administration;
- Lack of access to providers experienced in dealing with the member's health care needs;
- Significant language or cultural barriers;
- Corrective action levied against the Contractor by the office;
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the Contractor's contract with the State;
- A service is not covered by the Contractor for moral or religious objections, as described in Section 7.8.2;

- Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;

- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE; or

- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

5.2.1 Enrollment and Practice Discrimination

Per 42 CFR 438.3(d), the Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction. The Contractor shall not, on the basis of health status or need for health care services, discriminate against individuals. Additionally, the Contractor shall not discriminate against individuals on the basis of race, color, age, national origin, sex, sexual orientation, gender identity, genetic information, income status, [MLTSS Program Name] membership, or disability and will not use any policy or practice that has the effect of discriminating in such manner.

Examples of prohibited practices include, but are not limited to, the following:

1. Denying or not providing a member any covered service or access to an available facility,
2. Providing to a member any medically necessary covered service which is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary,
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in their enjoyment of any advantage or privilege enjoyed by others receiving any covered service, and
4. Assigning times or places for the provision of services on the basis of the race, color, age, national origin, sexual orientation, gender identity, genetic information, income status, [MLTSS Program Name] membership, or disability of the members to be served.

The Contractor shall assure members their rights as specified in 42 CFR 438.100.

The Contractor shall ensure members and individuals with disabilities are accommodated to actively participate in the provision of services and have physical access to facilities, procedures and exams. For example, the Contractor shall provide appropriate auxiliary aids and services to individuals with impaired sensory, manual, or speaking skills. The Contractor shall provide accommodations to members and individuals with disabilities at no cost to afford such individuals an equal opportunity to benefit from the covered services.

If the Contractor knowingly executes a subcontract with a provider with the intent of allowing or permitting the provider to implement barriers to care, (i.e. the terms of the subcontract act to discourage the full utilization of services by some members) the Contractor is in default of its Contract.

If the Contractor identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its providers, the Contractor shall promptly intervene and require a corrective action plan from the provider. Failure to take prompt corrective measures may place the Contractor in default of its Contract.

Contractor shall also adhere to Section 1557 of the Affordable Care Act / 45 CFR 92.1.

5.2.2 Enrollment Packet

Within five (5) calendar days of a new member's full enrollment with the Contractor in accordance with Section 5.7, the Contractor shall send the new member a Welcome Packet based on the State's model enrollee handbook. All information in the Enrollment Packet shall meet the general information requirements set forth in this section and shall be submitted for State review and approval prior to distribution in accordance with Section 5.7. The Welcome Packet shall include, but not be limited to, a new member letter, an explanation of where to find information about the Contractor's provider network, where to locate the member handbook including a summary of items found in the member handbook as described in Section 5.7.1, and the member's ID card. Refer to the [MLTSS Program Name] MCE Policies and Procedures Manual and Section 5.6 for specific information regarding [MLTSS Program Name] member ID card requirements.

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

5.2.3 PMP Selection

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

If a member fails to initially select a PMP, the Contractor shall assign the member to a PMP within thirty (30) calendar days of the member's enrollment. The Contractor should consider any prior provider relationships when making the assignment. FSSA must approve the Contractor's PMP auto-assignment process prior to implementation, and the process must comply with any guidelines set forth by FSSA. See the [MLTSS Program Name] MCE Policies and Procedures Manual for further detail. The Contractor shall notify the member in writing of the auto-assigned provider, the member's right to change PMP, as well as the process by which the member may change PMP.

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

Providers that may serve as PMPs include geriatricians, internal medicine physicians, general practitioners, family medicine physicians, endocrinologists (if primarily engaged in internal medicine), and physician extenders.

5.2.4 Provider Network and Provider Directory Information

The Enrollment Packet (described in section 5.2.3) shall include information on where to find information about the Contractor's provider network. Additionally, the Contractor shall include a current provider directory and/or information on how to find a network provider near the member's residence online and via the Member Helpline. In accordance with 42 CFR 438.10(h), the provider directory must include the following information:

1. Primary care physicians, specialists and hospitals;
2. Name, location and telephone number of providers;
3. Identification of non-English language spoken by providers;
4. Provider web sites, if applicable;
5. If the provider has accommodations for people with physical disabilities;
6. Describe the accommodations each provider has for people with physical disabilities;
7. Pharmacies and behavioral health providers;
8. Contact information for all brokers contracted with the MCE; and
9. Identification of providers that are not accepting new patients

A printed copy of the provider directory must also be available to members and FSSA upon request. The Contractor must include the aforementioned provider network information, by county, on its member website.

5.2.5 Member Disenrollment from MCE

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

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

Additional information about the member disenrollment process is provided in Exhibit 4 and the [MLTSS Program Name] MCE Policies and Procedures Manual.

5.3 Member-Contractor Communications

The Contractor will be responsible for developing and maintaining member education programs designed to provide members with clear, concise and accurate information about the Contractor's program, the Contractor's network and the [MLTSS Program Name] program. This should be delivered in a multimedia format that does not exclusively consist of telephonic and written correspondence outreach. The State encourages the Contractor to incorporate community advocates, community-based organizations, community health workers, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs.

The Contractor shall maintain strategies for communicating with members. Contractor communication strategies must meet the requirements under Section 5 Member Services and provide innovative approaches to ensure member understanding of the [MLTSS Program Name] program. The Contractor shall also develop approaches to share resources related to the member's goals which may include information about the member's health condition(s), treatment protocols and the importance of preventive care.

5.3.1 Member Services Helpline and 24-Hour Nurse Line

The Contractor shall maintain a statewide toll-free telephone helpline staffed with trained personnel knowledgeable about the [MLTSS Program Name] program equipped to handle a

variety of member inquiries, including the ability to address member questions, concerns, complaints and requests for PMP changes. The same helpline shall be available to [MLTSS Program Name] members, so that members may call one number to answer questions about all the IHCP programs the Contractor is contracted as an MCE for. The helpline shall be available to individuals who are authorized to speak to customer service on behalf of a member (e.g. a family member, informal caregiver, supported decision maker(s), legal guardian, or other designated representative). Indiana based helpline staff must take at least seventy percent (70%) of the member helpline calls, except when an emergency rollover is required. The State must be notified if such an emergency is taking place. A minimum of fifty percent (50%) of helpline staff must be employees of the prime Contractor.

The Contractor shall staff the member services helpline to provide sufficient “live voice” access to its members during, at a minimum, a twelve (12)-hour business day, from 8 a.m. to 8 p.m. Eastern, Monday through Friday. The call center shall open 60 days prior to the Contractor’s go live date, with State approval. The Contractor shall provide a voice message system that informs callers of the Contractor’s business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day.

The member helpline may be closed on the following holidays:

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

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

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

The member services helpline shall offer language translation services for members whose primary language is not English and shall offer automated telephone menu options in English and Spanish. A member services messaging option shall be available after business hours in English and Spanish. The Contractor shall provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members. There must also be at least one (1) fluent Burmese speaker and one (1) fluent Spanish speaker physically present (i.e., not via a language translation line) to answer member calls during all “live” operating hours.

Member services helpline staff shall be trained in the [MLTSS Program Name] program to ensure that member questions and concerns are resolved as expeditiously as possible. The Contractor shall have the ability to warm transfer members to outside entities including the Enrollment Broker, the Division of Family Resources (DFR) and provider offices. Additionally, the Contractor shall ensure the warm transfer of calls for members that require attention from a Contractor care manager or service coordinator. The Contractor shall ensure the care manager has access to all

information necessary to resolve the member's issues. Any messages left with care managers must be returned by the next business day.

The Contractor shall maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours. The Contractor shall monitor its member services helpline service and report its telephone service level performance to FSSA in the timeframes and specifications described in the [MLTSS Program Name] MCE Reporting Manual.

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

- Access to health care services;
- Identification or explanation of covered services;
- Special health care needs;
- Procedures for submitting a member grievance or appeal;
- Potential fraud or abuse including adult protective services;
- Changing PMPs;
- Incentive and enhanced benefit programs;
- Prevention and wellness programs(s), care coordination, and service coordination services;
- Balance billing issues;
- Referrals to local services or community-based organizations for assistance; and
- Health crises, including but not limited to suicidal callers.

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

The Contractor shall maintain sufficient equipment and staff to ensure the following:

- For any calendar month, at least ninety-seven percent (97%) of all phone calls to the helpline must reach the call center menu within thirty (30) seconds.
- For any calendar month, at least eighty-five percent (85%) of all phone calls to an approved automated helpline must be answered by a helpline representative within thirty (30) seconds after the call has been routed through the call center menu. Answered means that the call is picked up by a qualified helpline staff person.
- For any calendar month, at least ninety-five percent (95%) of all phone calls to an approved automated helpline must be answered by a helpline representative within sixty (60) seconds after the call has been routed through the call center menu. Answered means that the call is picked up by a qualified helpline staff person.
- If the Contractor does not maintain an approved automated call distribution system, for any calendar month, at least ninety-five percent (95%) of all phone calls to the helpline must be answered within thirty (30) seconds.
- Hold time does not exceed one (1) minute in any instance, or thirty (30) seconds, on average.
- For any calendar month, the lost call (abandonment rate) associated with the helpline does not exceed five percent (5%).

The Contractor shall provide a backup solution for phone service in the event of a power failure or outage or other interruption in service. Such plan shall include, at minimum, the following:

1. A notification plan that ensures FSSA is notified when the Contractor's phone system is inoperative or a back-up system is being utilized; and
2. Manual back-up procedure to allow requests to continue being processed if the system is down.

In addition to the member services helpline, which is staffed during regular business hours, the Contractor shall operate a toll-free twenty-four (24) hour nurse call line. The Contractor shall provide nurse triage telephone services for members to receive medical advice twenty-four (24) hours-a-day/seven (7)-days-a-week from trained medical professionals. The twenty-four (24) hour nurse call line should be well publicized and designed as a resource to members to help discourage inappropriate Emergency room use. The twenty-four (24) hour nurse call line must have a system in place to communicate all issues with the member's providers. In addition, as set forth in Section 3.4, the 24-Hour Nurse Call Line must be equipped to provide advice for [MLTSS Program Name] members seeking services from hospital Emergency departments.

5.3.2 Electronic Communications

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

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

The Contractor shall maintain the capability to report on email communications received and responded to, such as total volume and response times. The Contractor shall report required information to the State on electronic communications in accordance with the requirements outlined in the Reporting Manual.

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

5.4 Member Information, Education, and Outreach

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

The Contractor shall notify all members of their right to request and obtain information in accordance with 42 CFR 438.10. In addition to providing the specific information required at 42 CFR 438.10(f) upon enrollment in the Welcome Packet as described in Section 5.7 the Contractor shall notify members at least once a year of their right to request and obtain this information. Individualized notice shall be given to each member of any significant change in this information at least thirty (30) days before the intended effective date of the change. Significant change is defined as any change that may impact member accessibility to the Contractor's services and benefits.

The Contractor shall comply with the information requirements at 42 CFR 438.10. All enrollment notices, informational and instructional materials must be provided in a manner and format that is easily understood. This means, to the extent feasible, written materials shall not exceed a fifth-grade reading level and be in plain language. All written materials for members or potential members shall be in a font size no smaller than 12-point

In accordance with 42 CFR 438.10(e), the State must provide potential members with general information about the basic features of managed care and information specific to each MCE operating in the potential member's service area. At minimum, this information will include factors such as MCE service area, benefits covered, and network provider information. The State shall provide information on [MLTSS Program Name] MCEs in a comparative chart-like format. Once available, the State also intends to include Contractor quality and performance indicators on materials distributed to facilitate MCE selection. The State reserves the right to develop a rating system advertising Contractor performance on areas such as consumer satisfaction, network access and quality of care and services. To facilitate State development of these materials, the Contractor must comply with State, or its designee, requests for information needed to develop informational materials for potential members.

The Contractor shall make written information available in English and Spanish and other prevalent non-English languages identified by FSSA, upon FSSA's or the member's request. At the time of enrollment with the Contractor, the State shall provide the primary language of each member. The Contractor shall utilize this information to ensure communication materials are distributed in the appropriate language. In addition, the Contractor shall identify additional languages that are prevalent among the Contractor's membership. For purposes of this requirement, prevalent language is defined as any language spoken by at least three percent (3%) of the general population in the Contractor's service area. Written information shall be provided in any such prevalent languages identified by the Contractor.

Per Section 1557 of the Affordable Care Act / 45 CFR 92.1, the Contractor shall ensure that for significant publications and communications taglines (short statements written in non-English languages to alert individuals with limited English proficiency to the availability of language assistance services, free of charge, and how the services can be obtained) must be included in the State's top fifteen (15) languages spoken by limited English proficient populations, and for small-size significant publications and significant communications a tagline must be included in the State's top two languages spoken by limited English proficient populations. The Contractor will provide auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in the program.

Pursuant to the Americans with Disabilities Act of 1990 (ADA) / 42 USC §12101 et. seq., all communications with members must be consistent with the ADA's prohibition on unnecessary inquiries into the existence of a disability. Contractor shall have information available in alternative formats and through the provision of auxiliary aids and services for the Contractor's health programs and activities, in an appropriate manner that takes into consideration the member's needs, including those who have visual impairment or limited reading proficiency, and at no cost to the member.

5.5 Member and Stakeholder Education and Engagement

The Contractor must convene a minimum of four regional member and informal caregiver advocacy committees at least quarterly. These regional meetings shall occur in separate areas of the state, a minimum of sixty (60) miles from each other regional meeting occurring that quarter.

The purpose of the committees is to provide member, informal caregiver, and advocate input into program development and feedback on the member experience. The Contractor shall present information to the committee and seek its advice regarding: the experience of members and their informal supports service gaps, approaches to member outreach and education, reinvestment opportunities, and regarding Contractor's proposed approaches to initiatives and interventions Contractor will implement to improve quality of care.

The committee shall review member materials, including the member handbook and website, and review the Contractor's Health Equity and Cultural Competency plan.

The Contractor shall have a feedback loop with the committee on recommendations taken and not taken.

The committee shall review trends and summaries of member grievances and appeals. The committee shall be asked to provide advice to the Contractor on how the Contractor can resolve common member concerns.

The Contractor shall include a cross representation of members, families/representatives, and advocacy groups that reflect the population and community served specifically a majority of people with lived experiences. Sub-committees may be created to focus on specific topics such as LTSS or Behavioral Health.

The Contractor shall facilitate member participation providing transportation, interpretation services, compensation, virtual connectivity, meetings conducted in the prevalent non-English languages of the membership, personal care assistance, and compensation for attendance (through an enhanced benefit). The contractor shall provide thirty (30) days advance notice to participants. Meetings shall be conducted in various formats such as informational or decision-making meetings, or focus groups.

The Contractor shall have member advocacy organizations as standing members of the committee, especially organizations with a focus on and led by individuals with special health care needs, aging individuals, individuals with disabilities, and social determinant of health organizations.

FSSA compliance staff shall be informed of each meeting time and location at least two weeks in advance, so they may plan to attend. Minutes from the meetings shall be provided to the MCE's Board of Directors and to FSSA within one month of the meeting date.

The Contractor shall also develop a formal process for ongoing education of stakeholders prior to, during and after implementation of the [MLTSS Program Name]. This includes publicizing methods by which members can ask questions regarding the [MLTSS Program Name] program. Stakeholders include, but are not limited to, providers, advocates and members. The Contractor shall submit this formal process to FSSA for review and approval in the timeframe and manner determined by the State.

5.6 Member ID Card

Within five (5) calendar days of a new member's full enrollment with the Contractor, the Contractor must send the member a new ID card. A new ID card must be mailed to the member after any break in coverage of more than fifteen (15) days and upon request of a member. The ID card must be durable and shall comply with all State and Federal requirements and at a minimum, shall include:

1. The Contractor's name and [MLTSS program name] program logo.
2. Phone numbers for information
3. Phone numbers for information and/or authorizations, including for physical health, behavioral health, and long-term services and supports;
4. Descriptions of procedures to be followed for emergency or special services;

5. The member's State assigned identification number. No other identification numbers may be used;
6. The member's name (First, Last and Middle Initial);
7. The member's enrollment effective date;

For members dually-eligible for Medicaid and Medicare who are enrolled in a DSNP, refer to Section 2.21.2 Dual Eligible Special Needs Plan (D-SNPs) Requirements and Coordination for additional requirements.

5.7 Member Materials

The Contractor shall distribute member materials as required by this Contract. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters and identification cards at a minimum. The Contractor may distribute additional materials and information, other than those required to members in order to promote health and/or educate enrollees provided the materials are State approved. Materials, to the extent possible, shall be in plain language including the Member Welcome Letter and Member Handbook.

5.7.1 Member Welcome Letter

Within five (5) calendar days of a new member's full enrollment with the Contractor, the Contractor must send the member a Welcome Letter. The Welcome Letter shall include:

- Education confirming the member's enrollment with Contractor as part of the [MLTSS Program Name] Contractor contact information with an explanation as to how can access information
- Specific information on coordination of care with current providers and how members can receive care coordination assistance
- Member's effective enrollment date with Contractor

5.7.2 Member Handbook

Within five (5) calendar days of a new member's full enrollment with the Contractor in accordance with Section 5.8, the Contractor shall develop and send the member a Member Handbook. The Contractor's member handbook shall be submitted annually for FSSA's review, and any time changes are made. The member handbook shall include the Contractor's contact information and Internet website address and describe the terms and nature of services offered by the Contractor, including the following information required under 42 CFR 438.10(f), which enumerates certain required information. The member handbook may be offered in an electronic format as long as the Contractor complies with 42 CFR 438.10(c)(6). The [MLTSS Program Name] MCE Policies and Procedures Manual outlines the member handbook requirements.

The [MLTSS Program Name] member handbook shall include the following:

1. Contractor's contact information (address, telephone number, TDD number, website address);
2. The amount, duration and scope of services and benefits available under the Contract in sufficient details to ensure that members are informed of the services to which they are entitled, including, but not limited to the differences between the benefit options;
3. The procedures for obtaining benefits, including authorization requirements;
4. Contractor's office hours and days, including the availability of a 24-hour Nurse Call Line;
5. Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out-of-network providers;

6. How emergency care is provided, that an authorization is not required, and that the enrollee has a right to use any hospital or other setting for emergency care;
7. The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(f), such as what constitutes an emergency;
8. The post-stabilization care services rules set forth in 42 CFR 422.113(c);
9. The extent to which, and how, urgent care services are provided;
10. Applicable policy on referrals for specialty care and other benefits not provided by the member's PMP, if any;
11. Information on available Home and Community Based Services (HCBS) benefits and education on how to access HCBS;
12. Information on long-term services and supports and education on how to access long-term services and supports;
13. Information about the availability of pharmacy services and how to access pharmacy services;
14. Information about all relevant or applicable State ombudsman programs.
15. Member rights and protections, as enumerated in 42 CFR 438.100, which relates to enrollee rights. See Section 5.11 for further detail regarding member rights and protections;
16. Information about the member's right to choose between nursing facility and HCBS.
17. A description of the Care Coordinator and Service Coordinator role and responsibilities
18. Responsibilities of members;
19. Special benefit provisions (for example, co-payments, deductibles, limits or rejections of claims) that may apply to services obtained outside the Contractor's network;
20. Procedures for obtaining out-of-network services;
21. Standards and expectations to receive preventive health services;
22. Policy on referrals to specialty care;
23. Procedures for notifying members affected by termination or change in any benefits, services or service delivery sites;
24. Procedures for appealing decisions adversely affecting members' coverage, benefits or relationship with the Contractor;
25. Information on how to access non-emergency medical transportation and how the member can access assistance with their responsibilities for scheduling, using, and cancelling rides through the Contractor's transportation broker or care management;
26. Procedures for changing PMPs;
27. Standards and procedures for changing MCEs, and circumstances under which this is possible, including, but not limited to providing contact information and instructions for how to contact the enrollment broker to transfer MCEs due to one of the "for cause" reasons described in 42 CFR 438.56(d)(2)(iv), including, but not limited to, the following:
    a. Receiving poor quality of care;
    b. Failure to provide covered services;
    c. Failure of the Contractor to comply with established standards of medical care administration;
    d. Lack of access to providers experienced in dealing with the member's health care needs;
    e. Significant language or cultural barriers;
    f. Corrective action levied against the Contractor by the office;
    g. Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
    h. A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
    i. Lack of access to medically necessary services covered under the Contractor's contract with the State;
    j. A service is not covered by the Contractor for moral or religious objections, as described in Section 7.8.2;
    k. Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider

determines that receiving the services separately will subject the member to unnecessary risk;

l. The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE; or
m. Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

28. The process for submitting disenrollment requests. This information shall include the following:
    a. When members may change MCEs (as detailed in Section 5.2)
    b. Members may submit requests to change MCEs to the Enrollment Broker verbally or in writing
29. The MCE shall provide the Enrollment Broker's contact information and explain that the member must contact the Enrollment Broker with questions about the process. The process by which an American Indian/ Alaska Native member may elect to opt-out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for-service benefits through the State;
30. Procedures for making complaints and recommending changes in policies and services;
31. Grievance, appeal and fair hearing procedures as required at 42 CFR 438.10(g)(2)(xi), including the following:
    a. The right to file grievances and appeals;
    b. The requirements and timeframes for filing a grievance or appeal;
    c. The availability of assistance in the filing process;
    d. The toll-free numbers that the member can use to file a grievance or appeal by phone;
    e. The fact that, if requested by the member and under certain circumstances: (1) benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and (2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.
32. For a State hearing, describe (i) the right to a hearing, (ii) the method for obtaining a hearing, and (iii) the rules that govern representation at the hearing.
33. Information about advance directives;
34. How to report a change in income, change in family size, etc.;
35. Information about the availability of the prior claims payment program for certain members and how to access the program administrator;
36. Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats;
37. Information on how to contact the Enrollment Broker, the Member Support Services contractor (5.14.9) and other State-designated entities involved in enrollment services, member support services, and choice counseling.
38. Information on Medicare eligibility and when to enroll;
39. Statement that Contractor will provide information on the structure and operation of the health plan; and
40. In accordance with 42 CFR 438.10(f)(3), that upon request of the member, information on the Contractor's provider incentive plans will be provided.

5.7.3 Member Website

The Contractor shall provide and maintain a website for members to access information pertaining to the program and the Contractor's services. The website shall be in an FSSA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines. The website shall be live and meet the requirements of this section on the effective date of the Contract. FSSA must pre-approve the Contractor's website information and graphic presentations. The website shall be accurate and current, culturally appropriate, written for understanding at a fifth-grade reading level, in plain language, and available in English and Spanish. The Contractor shall inform members that information is

available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor must make a version available in a format that is optimized for mobile phone use. The Contractor's member portal and website shall be designed with ease of access for an aging population and caretakers in mind.

The Contractor shall date each web page, change the date with each revision and allow users print access to the information. The website must include the information required in the Enrollment Packet as described in Section 5.2.2. Such website information shall include, at minimum, the following:

- The Contractor's searchable provider network identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access and other demographic information as described in Section 6.15. The Contractor must update the on-line provider network information every two (2) weeks, at a minimum;
- The Contractor's contact information for member inquiries, member grievances and appeals;
- The Contractor's member services phone number, TDD number, hours of operation and after-hours access numbers, including the 24-hour Nurse Call Line;
- A member portal with access to electronic Explanation of Benefit (EOB) statements,
- Preventive care and wellness information;
- Information about the cost and quality of health care services, as further described in Section 5.7.6;
- A description of the Contractor's prevention and wellness programs(s) programs and care coordination services;
- The member's rights and responsibilities, as enumerated in 42 CFR 438.100. Please see Section 5.11 for further details regarding member rights;
- The member handbook;
- Contractor-distributed literature regarding all health or wellness promotion programs that are offered by the Contractor;
- Information on the value and benefits of aging at home;
- Contractor's marketing brochures and posters;
- The Health Insurance Portability and Accountability Act (HIPAA) privacy statement;
- Links to FSSA's website for general Medicaid and [MLTSS Program Name] information;
- Information on pharmacy locations and preferred drug lists applicable to each program and benefit package;
- List of all prior authorization criteria for prescription drugs, including mental health drugs;
- Transportation access information;
- Information about how members may access dental services and how to access the Contractor's dental network;
- A list and brief description of each of the Contractor's member outreach and education materials;
- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report;
- Information on behavioral health covered services and resources; and
- A secure portal through which members may complete the Health Needs Screening described in Section 4.5.

5.7.4 Preventive Care Information

The Contractor is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care evidence-based standards. Further information on education requirements for disease specific conditions and prevention and wellness programs(s) and care coordination communications is provided in Section 4. The Contractor shall, on an ongoing basis, contact via all appropriate media any member who has not

utilized preventive services or has no claims activity within the last 15 months to schedule preventive care.

5.7.5 Member Education

The Contractor shall provide members with general information about the benefits covered under the program. The Contractor shall have policies and procedures in place to ensure that member education information is accurate in content, accurate in translation relevant to language, and do not defraud, mislead, or confuse the member. Member education shall include, but not necessarily limited to the items noted below:

- Information on benefit coverage
- How to access the health care system appropriately (i.e. keeping appointments, appropriate use of Emergency Room services, how to file grievances and appeals)
- Information on covered dental services

5.7.6 Cost and Quality Information

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

For services that may be at risk for improper payments, the Contractor must develop processes to verify with members that said targeted services billed by providers were actually received by said members, in order to obtain direct verification of services rendered and increase oversight. processes and procedures must be identified in the Contractor's Program Integrity Plan, identified in Section 8.1. Specific services for member verification may be identified by the OMPP PI Section and may change based upon fraud trends. Processes for verifying services with members shall be included in the Contractor's Program Integrity Plan.

The Contractor shall provide a member portal with access to electronic EOB statements for members.

Provider quality information shall also be made available to members. The Contractor shall capture quality information about its network providers and must make this information available to members. In making the information available to members, the Contractor shall identify any limitations of the data. The Contractor shall also refer members to quality information compiled by credible external entities.

5.8 Member and Potential Member Communications Review and Approval

All member and potential member communications required in this section or otherwise developed by the Contractor must be pre-approved by FSSA. The Contractor must develop and include a Contractor-designated inventory control number on all member marketing, education, training, outreach and other member materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate FSSA's review and approval of member materials and document its receipt and approval of original and revised documents.

The Contractor shall submit all member and potential member communications, including letters, bulletins, forms, advertisements, notices, handbooks, brochures and any other marketing, educational or outreach materials to FSSA for review and approval at least thirty (30) calendar days prior to expected use and distribution. Substantive changes to member and potential member communications shall also be submitted to FSSA for review and approval at least thirty (30) calendar days prior to expected use and distribution.

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

All member communication materials that have been approved by FSSA may be distributed by the Contractor for the period of the contract and must be re-approved after any contract renewals.

FSSA will assess liquidated damages as set forth in Exhibit 2 and impose other authorized remedies for the Contractor's non-compliance in the use or distribution of any non-approved member or potential member communications.

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

5.9 Redetermination Assistance

Contractors may assist members in the eligibility Medicaid redetermination process. Permitted assistance includes:

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

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

- Discriminating against members, particularly high-cost members or members that have indicated a desire to change MCEs;
- Talking to members about changing MCEs (if a member has questions or requests to change MCEs, the Contractor shall refer the member to the Enrollment Broker);
- Providing any indication as to whether the member will be eligible (this decision shall be made by DFR);
- Engaging in or support fraudulent activity in association with helping the member complete the redetermination process;
- Signing the member's redetermination form; or
- Completing or send redetermination materials to DFR on behalf of the member.

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

5.10 Member-Provider Communications

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

1. The member's health status, medical care, treatment options, or social supports including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under Medicaid;

2. Any information the member needs in order to decide among all relevant treatment and service options;

3. The risks, benefits, and consequences of treatment or non-treatment; and

4. The member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

This provision does not require the Contractor to provide coverage for a counseling or referral service if the Contractor objects to the service on moral or religious grounds in accordance with 42 CFR 438.102. The Contractor may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

See section 5.2.4 for provider directory requirements.

5.11 Member Rights

The Contractor shall guarantee and have written policies guaranteeing the following rights protected under 42 CFR 438.100 to its members:

1. The right to receive information in accordance with 42 CFR 438.100, which relates to information on the managed care program and plan in which the member is enrolled

2. The right to be treated with respect and with due consideration for the member's dignity and privacy;

3. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

4. The right to participate in decisions regarding the member's health care, including the right to refuse treatment;

5. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;

6. The right to request and receive a copy of the member's medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information; and

7. The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

8. For those members who are receiving HCBS, the right to have and review their service plan (of care) as outlined in 42 CFR 441.301(b)(1)(I).

9. The right to review their care plan for all members as described in Section 4.9 For those members who are receiving home and community based long-term services and supports, the right to request a fair hearing outlined in 42 CFR 431 Subpart E when an individual is not given

the choice of home and community-based waiver services as an alternative to institutional level of care, who are denied the service(s) of their choice or the provider(s) of their choice, or whose services are denied, suspended, reduced, or terminated. The right to request a fair hearing includes providing a notice of action per 42 CFR 431.210.

The Contractor shall also comply with other applicable state and federal laws regarding member rights, as set forth in 42 CFR 438.100 The Contractor shall have a plan in place to ensure that its staff and network providers take member rights into account when furnishing services to the Contractor's members. Members shall be free to exercise protected member rights, and the Contractor shall not discriminate against a member that chooses to exercise their rights.

5.12 Additional Information Available Upon Request

The Contractor shall have written policies guaranteeing to provide all other information to members as required by CMS, including but not limited to the following information to any enrollee who requests it.

The Contractor shall inform members that information is available upon request in alternative formats and how to obtain them. OMPP defines alternative formats as braille, large font letters, audiotape, prevalent languages and verbal explanation of written materials. The Contractor shall offer braille as an alternative format for receiving member materials. When a member has requested materials in braille, the Contractor shall supply future materials in braille to the member. The Contractor may review with the member the specific document types the member wishes to receive in braille versus other formats.

Unless a member specifically states their alternate-format request is a one-time request, the Contractor shall consider the request an ongoing request and supply all future mailed materials in the preferred format to the member.

For first-time or one-time requests from a member, the Contractor shall mail the alternate version of the document in no more than seven (7) business days from the date of the request. If, for example, the member received a wellness visit reminder flyer and called the Contractor to ask for the flyer to be sent in braille, the Contractor shall take no more than seven (7) business days to mail the braille version from the date of the member request call.

For first-time or one-time requests from a member, when the mailing is governed by NCQA or statutory requirements, the Contract shall have two (2) additional days from the NCQA or statutory timeframe to mail the document if no mailing has yet been sent to the member. For first-time or one-time requests from a member, when the mailing is governed by NCQA or statutory requirements and the statutory notice has already been fulfilled with a regular printed letter, the Contractor shall mail the alternate version of the document in no more than seven (7) business days from the date of the request.

For existing on-going alternate format requests, the Contractor shall have two (2) additional business days from when the document would normally be required to be mailed, to mail the document in the alternate format. If, for example, a member had previously requested materials in braille, and an ID card would be sent to the member in five (5) business days, the timeline would be seven (7) business days for the braille version. The additional two (2) days applies for Contract requirements (such as ID cards) and additional mailings at the will of the Contractor, such as a wellness visit reminder postcard.

For existing on-going alternate format requests which must comply with NCQA or State law requirement, such as utilization management letters, the Contractor shall mail the documents in the alternate format within the statutory or NCQA required timeline.

The Contractor shall provide notification to FSSA, to the Enrollment Broker, to the Member Support Services contractor (5.14.9), and to its members of any covered services that the Contractor or any of its sub-contractors or networks do not cover on the basis of moral or religious grounds and guidelines for how and where to obtain those services, in accordance with 42 CFR 438.102, which relates to provider-enrollee communications. This information shall be relayed to the member before and during enrollment

and within ninety (90) calendar days after adopting the policy with respect to any particular service. Refer to Section 7.8.2 for additional information.

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

Grievance, appeal and fair hearing procedures and timeframes shall be provided to members in accordance with 42 CFR 438.10(g)(2)(xi), which requires specific information be provided to enrollees. Please see Section 5.14 for further information about grievance, appeal and fair hearing procedures, as well as the kind of information that the Contractor shall provide to members.

The Contractor shall be responsible for developing and maintaining member education programs designed to provide the members with clear, concise and accurate information about the Contractor's program and the Contractor's network. The State encourages the Contractor to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the Contractor to develop community partnerships with these types of organizations, in particular with, community mental health centers, county health departments and community-based organizations that serve older adults and/or persons with disabilities to promote health and wellness within its membership.

The Contractor is required to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider (including HCBS providers) on a regular basis going back twelve (12) calendar months. Such notice must be provided to members at least thirty (30) calendar days prior to the effective date of the termination. However, if the practice or practitioner notifies the Contractor less than (thirty) 30 days prior to the effective date of the termination, the Contractor shall then notify members as soon as possible but no later than fifteen (15) calendar days after receipt of the notification from the practice or practitioner. Additionally, upon the request of a member, the Contractor shall also provide information on the structure and operation of the health plan as well as information on physician incentive plans.

In the first and third quarter of every Contract year, the Contractor shall identify members who are potentially eligible for the Supplemental Nutritional Assistance Program (SNAP). The Contractor shall use the federal poverty level of 130% to identify potentially eligible members. The Contractor shall conduct an educational outreach campaign to the members identified as potentially eligible. The Contractor does not need to outreach to all potentially eligible members at once but can conduct outreach on a rolling basis during the quarter identified and the following quarter (e.g., reach out to each potentially eligible member once in the first or second quarter and once again in the third or fourth quarter of every Contract year). The educational information provided to members shall include information on SNAP benefits, eligibility, and how to enroll. The Contractor shall develop communication strategies that meet the requirements of this section and provide innovative approaches to ensure member understanding of the program. The Contactor shall, at minimum, provide program information to the member through required notices and other communications prescribed by the State.

The Contractor's educational activities and services shall also address the needs of specific program subpopulations (e.g. I/DD, dementia, members with complex needs, etc.) as well as its general membership. The Contractor must have a comprehensive member outreach strategy to make persons aware of the benefits available it's members The Contractor shall demonstrate how these educational interventions reduce barriers to health care, social supports, and improve outcomes for members.

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

5.13 Procedures Regarding Potential Abuse, Neglect, and Exploitation (ANE) of Older Adults

5.13.1 Contractor Responsibility

Indiana is a mandatory report state, meaning everyone is required by law to report cases of suspected neglect, battery or exploitation of an endangered adult to an APS unit or law enforcement. The Contractor will make reasonable efforts through member interactions, education, and interventions (such as but not limited to supporting a member's connection to community supports) to ensure that members are free from abuse, neglect, self-neglect and exploitation (ANE). The Contractor will provide educational materials and training opportunities to members, families, informal caregivers, guardians, and providers which cover the prevention, identification, and reporting of ANE of older adults.

The Contractor will ensure prompt reporting and communication with the State and other appropriate entities regarding incidents of ANE and will proactively provide interventions to members regarding the ANE.

5.13.2 Policies and Procedures

The Contractor shall have policies, procedures, protocols and training to ensure that Contractor staff and any subcontractor staff that provide services to members:

- Are able to recognize and screen members for signs of abuse, neglect, self-neglect, and exploitation as defined in 455 IAC. 2-4-2; 455 IAC. 1-2-2(g-h)
- Screening of members for ANE will take place initially, upon signs of ANE, or regularly if the member has a history of ANE; screening tools must be verified by the National Center on Elder Abuse or must be another evidence-based tool approved by the State.
- Identify members who may be at risk of abuse, self-neglect and exploitation and in need of adult protective services (APS) or the services of the State Long-Term Care (LTC) Ombudsman or the Indiana Department of Health.
- Support at-risk members, families, informal caregivers, and guardians with resources on ANE prevention, including informal caregiver education and support and strategies to reduce member and informal caregiver social isolation.
- Understand reporting requirements and report incidents involving member abuse, neglect, self-neglect and exploitation consistent with IC 12-10-3-9.
- Refer members at risk or in need of services to the appropriate resource including the LTC Ombudsman, or other appropriate agency, such as an Area Agency on Aging.
- Report within 24 hours to the State regarding incidents of ANE, including interventions underway and anticipated intervention as described in section 7.1.14;
- Update the member's care plan as needed to balance member needs for safety, protection, physical health, and freedom from harm with overall quality of life and individual choice. Each issue of safety and risk shall be incorporated individually into the member's care plan.
- Ensure that members, families, informal caregivers, and guardians and staff are provided educational materials on ANE prevention, recognition, and reporting with training materials that are approved by the State.
- Follow-up to ensure that member needs are addressed on an ongoing basis.
- Follow up on intervention success will be done within a week and will be reported to the

State.

5.13.3 Access to Adult Protective Services (APS), Long-Term Care Ombudsman Program, and Member Support Services

For members where APS or the Long-Term Care (LTC) Ombudsman, or Member Support Services contractor may need to be involved, the Contractor shall may involve the entity in the following capacities:

- The Contractor will, as appropriate, invite an APS/ the LTC Ombudsman, or Member Support Services contractor to participate in the member-centered planning process including plan development and updates, comprehensive assessment and re-assessments;
- The Contractor will, as appropriate, invite an APS/LTC Ombudsman staff person, or Member Support Services contractor to participate on the interdisciplinary team to the extent that the staff person makes recommendations as necessary to fulfill their APS/ LTC Ombudsman or Member Support Services responsibilities; and
- The Contractor will designate a staff person to serve as a member advocate and liaison between APS, LTC Ombudsman, Member Support Services contractor, and the member to assist APS and LTC Ombudsman staff, or Member Support Services contractor working in developing service options for The Contractor's members or potential members.

5.13.4 Examination and Treatment Services

The Contractor will arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of elder abuse, abuse of adults with intellectual or developmental disabilities, and domestic violence. Such expertise shall include the identification of possible and potential victims of elder abuse and domestic violence, statutory reporting requirements, and local community resources for the prevention and treatment of elder abuse and domestic violence.

The Contractor will ensure that members, who must be separated from an alleged abuser, are immediately transitioned to another setting. Continuity of care shall be upheld during and after the transition. The Contractor will consult with human service agencies on appropriate providers in their community.

The Contractor will further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse, elder abuse, and incest are utilized in service provision including trauma counseling and resource connection for members who have experienced ANE.

5.13.5 Memoranda of Understanding and Outreach to Adult Protective Services, Long-Term Care Ombudsman, and Member Support Services

The Contractor will make efforts to build working relationships with all the APS units and Long-Term Care (LTC) Ombudsman and Member Support Services programs through regular meetings and written policies. The Contractor may enter into memorandums of understanding with the Indiana's Adult Protective Services units and the Long-Term Care (LTC) Ombudsman and Member Support Services programs. MOUs will follow the policies and procedures issued by the State and shall be submitted to the State for review and approval.

5.14 Member Inquiries, Grievances & Appeals

The Contractor shall establish written policies and procedures governing the resolution of inquiries, grievances and appeals. At a minimum, the grievance system must include a grievance process, an

appeals process, expedited review procedures and access to external grievance procedure, as well as the State's fair hearing system. The Contractor shall maintain records of grievances and appeals in accordance with 42 CFR 438.416 which includes the following:

- A general description of the reason for the appeal or grievance;
- The date received;
- The date of each review or, if applicable, review meeting;
- Resolution at each level of the appeal or grievance, if applicable;
- Date of resolution at each level, if applicable;
- Name of the covered person for whom the appeal or grievance was filed;
- The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.

The State will review this information as part of the State's quality strategy. The Contractor's grievances and appeals system, including the policies for recordkeeping and reporting of grievances and appeals, must comply with law, including 42 CFR 438, Subpart F as well as IC 27-13-10 and IC 27-13-10.1 (if the Contractor is licensed as an HMO) or IC 27-8-28 and IC 27-8-29 (if the Contractor is licensed as an accident and sickness insurer). The Contractor shall operate unified appeals and grievance processes with their companion DSNP plan, meeting the requirements in 42 CFR 422.629 through 42 CFR 422.634.

The term *inquiry* refers to a concern, issue or question that is expressed orally by a member that will be resolved by the close of the next business day.

The term *grievance,* as defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an "adverse benefit determination" as defined below. This may include dissatisfaction related to the quality of care of services rendered or available, aspects of interpersonal relationships, such as rudeness of a provider or employee or the failure to respect the member's rights.

The term *appeal* is defined as a request for a review of an action. An *adverse benefit determination,* as defined in 42 CFR 438.400(b) is any of the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service excluding the denial of a claim that does not meet the definition of a clean claim. A "clean claim" is one in which all information required for processing the claim is present;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of a Contractor to act within the required timeframes;
- For a resident of a rural area with only one Contractor, the denial of a member's request to exercise their right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network (if applicable); or
- Denial of a member's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

The Contractor must notify the requesting provider, and give the member written notice, of any decision considered an "adverse benefit determination" taken by the Contractor, including any decision by the Contractor to deny a service authorization request (a request for the provision of a service by or on behalf of a member), or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404 and must include:

- The adverse benefit determination the Contractor has taken or intends to take;
- The reasons for the adverse benefit determination;
- The member's or the provider's right to file an appeal and the procedure for requesting such an appeal;
- The procedure to request an external grievance procedure (External Review by Independent Review Organization) following exhaustion of the Contractor appeals process;

- The procedure to request a State fair hearing following exhaustion of the Contractor appeals process;
- The circumstances under which expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending resolution of the appeal, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services.

5.14.1 Contractor Grievance and Appeals Policies

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

- The Contractor must not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member, in accordance with 42 CFR 438.102. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.
- The Contractor must not take punitive action against a provider who requests or supports an expedited appeal on behalf of a member.
- Throughout the appeals process, the Contractor must consider the member, representative or estate representative of a deceased member as parties to the appeal
- In accordance with 42 CFR 438.406, provide the member and their representative opportunity, before and during the appeals process, to provide a copy of the member's case file, including medical records and any other documents or records considered during the appeals process.
- Allow the member and member representative to present evidence, and allegations of fact or law, in person as well as in writing.
- Inform the member and member representative of the limited time available to present evidence and allegations of fact or law, in the case of expedited appeal resolution.
- Upon determination of the appeal, ensure there is no delay in notification or mailing to the member and member representative of the appeal decision. The Contractor's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).
- The Contractor must acknowledge receipt of each grievance and appeal via all methods determined by the State.
- The Contractor must notify members of the disposition of grievances and appeals pursuant to IC 27-13-10-7 (if the Contractor is licensed as an HMO) or IC 27-8-28-16 (if the Contractor is licensed as an accident and sickness insurer).
- The Contractor must provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Oral interpretation services shall not substitute for written translation of vital materials in accordance with 42 CFR 438.408(d)(1) and 42 CFR 438.10.
- The Contractor should routinely review grievance and appeal data and information to determine broad member impact and how to improve member experience and care.
- The Contractor must ensure that the individuals rendering decisions on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise (medical, surgical or diagnostic expertise as pertinent to case) in treating the member's condition or disease if the decision will be in regard to any of the following:
    - An appeal of a denial based on lack of medical necessity;
    - A grievance regarding denial of expedited resolution of an appeal; and
    - Any grievance or appeal involving clinical issues.

FSSA reserves the right to require the Contractor to utilize a universal member grievance and appeal form provided by FSSA.

5.14.2 Inquiry Processing Requirements

The Contractor shall resolve inquiries by the close of the next business day after receipt. If an inquiry is not resolved in this timeframe, it becomes a grievance. An inquiry resolved in the required timeframe does not require a written notice of resolution to the member. The Contractor shall maintain a system for tracking and reporting inquiries it receives during business and non-business hours.

5.14.3 Grievance Processing Requirements

In accordance with 42 CFR 438.402, members must be allowed to file grievances orally or in writing. Members may file a grievance regarding any matter other than those described in the definition of an adverse benefit determination as described in Section 5.14. Grievances must be filed within sixty (60) calendar days of the occurrence of the matter that is the subject of the grievance.

The Contractor must acknowledge receipt of each grievance within three (3) business days. For grievances, the Contractor is not required to acknowledge receipt of the grievance in writing, however, if the member requests written acknowledgement, the acknowledgement must be made within five (5) business days of receipt of the request. The Contractor must make a decision on non-expedited grievances as expeditiously as possible, but not more than thirty (30) calendar days following receipt of the grievance. This timeframe may be extended up to fourteen (14) calendar days if resolution of the matter requires additional time. If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. The Contractor shall provide the member with a written notice of any extension within two (2) calendar days of the extension, including the reason for the extension and the member's right to file a grievance if they disagree with the extension.

The Contractor shall provide an expedited grievance review if adhering to the resolution timeframe of thirty (30) calendar days would seriously jeopardize the life or health of a member, or the member's ability to regain maximum function, or by the member's request. Expedited grievances must be resolved within forty-eight (48) hours of receipt. If the Contractor denies a request for an expedited review, the Contractor shall transfer the grievance to the standard grievance timeframe. Further, the Contractor must make a reasonable effort, including a phone call to the member, to provide the member with prompt oral notification of the denial for an expedited review, and shall follow up with a written notice to the member and, where appropriate, the provider within two (2) calendar days.

The Contractor shall respond in writing to a member within five (5) business days after resolving a grievance or expedited grievance. The resolution includes notice of the member's right to file an appeal, the process for requesting an appeal, the expedited review options, the right to continue benefits during the appeal (as long as the request complies with timeliness standards), and an explanation that the member may have to pay for care received if an adverse appeal decision is made. For grievances related to a member's request to change MCEs, information on how to request a plan change must be included in the notice. The Contractor must make a reasonable effort, including a phone call to the member, to provide oral notification of expedited grievance resolution. For grievances related to violations of the setting rule (42 CFR 441.301(c)) the Contractor shall report to their OMPP contact the outcome of the Contractor's grievance review.

5.14.4 Appeals Processing Requirements

Members shall have sixty (60) calendar days from the date of adverse benefit determination notice to file an appeal. In accordance with 42 CFR 438.402, a provider, acting on behalf of the member, and with the member's written consent, may file an appeal. In accordance with 42 CFR 438.406, the Contractor shall ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. For oral appeals with expedited resolutions the Contractor shall maintain documentation of the oral appeal and its resolution.

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

The Contractor shall maintain an expedited review process for appeals when the Contractor or the member's provider determines that pursuing the standard appeals process could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Contractor must dispose of expedited appeals within forty-eight (48) hours after the Contractor receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c). In accordance with 42 CFR 438.410, if the Contractor denies the request for an expedited resolution of a member's appeal, the Contractor must transfer the appeal to the standard thirty (30) calendar day timeframe and give the member written notice of the denial within two (2) days of the expedited appeal request. The Contractor must also make a reasonable attempt to give the member prompt oral notice, including a phone call to the member.

In accordance with 42 CFR 438.408, written notice of appeal disposition must be provided to the member and, where appropriate, the provider. Notice shall be provided within five (5) business days of resolution. For notice of an expedited resolution, the Contractor must also make reasonable efforts, including a phone call to the member, to provide oral notice. The written notice of the resolution must include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice must include the right to request an external grievance procedure (External Review by Independent Review Organization) and State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. This shall also include notice that the member may be held liable for the cost of those benefits if the State hearing upholds the Contractor's adverse benefit determination as set forth in Section 5.14.7 Continuation of Benefits Pending Appeal & Reinstatement of Benefits. For appeals related to a member's request to change MCEs, information on how to request a just cause plan change must be included in the notice.

5.14.5 External Review by Independent Review Organization

In accordance with IC 27-13-10.1-1 and IC 27-8-29-12, the Contractor shall maintain an external grievance procedure for the resolution of decisions related to an adverse utilization review determination, an adverse determination of medical necessity or a determination that a proposed service is experimental or investigational. Members must first exhaust the Contractor's grievance and appeals process. An external review does not inhibit or replace the member's right to appeal a Contractor decision to a State fair hearing. A member may seek external review by an Independent Review Organization (IRO), and such process may run concurrently with a State fair hearing.

Within one hundred and twenty (120) calendar days from the date of the Contractor's decision on the member's appeal, a member, or a member's representative may file a written request for a review of the Contractor's decision by an independent review organization (IRO). The IRO

shall render a decision to uphold or reverse the Contractor's decision within seventy-two (72) hours for an expedited appeal, or fifteen (15) business days for a standard appeal. The determination made by the independent review organization is binding on the Contractor. IRO clinicians do not have to be Indiana licensed.

5.14.6 State Fair Hearing Process

In accordance with 42 CFR 438.408, the State maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions to the State. Contractor should refer to 405 IAC 1.1 for the appeal procedures for applicants and recipients of Medicaid.

Members must first exhaust the Contractor's grievance and appeals process. The Contractor must timely coordinate the grievance and appeal process. Within one hundred and twenty (120) calendar days of exhausting the Contractor's internal procedures, the member may request a FSSA fair hearing. As noted above, this process may run concurrent to an external review by an IRO.

The parties to the State fair hearing shall include the Contractor, as well as the member and the member's representative or the representative of a deceased member's estate. If dissatisfied with the outcome of the State fair hearing, the member may request an agency review within ten (10) days of the administrative law judge's decision. An agency decision may be brought before a judicial review pursuant to 405 IAC 1.1-3-1. The Contractor will be subject to the contract compliance remedies (set forth in Exhibit 2 Contract Compliance and Pay for Outcomes) for failing to provide a timely and satisfactory response to documentation required for an appeal or failure to represent the state at the State fair hearing.

The Contractor must include the external grievance procedure (External Review by Independent Review Organization) and the State fair hearing process as part of the written internal process for resolution of appeals and must describe the processes in the member handbook described in Section 5.7.2. All notices of actions with appeal rights and notices of final action by the Contractor where the next course of action is a State Fair Hearing shall have the following language included:

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

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

5.14.7 Continuation of Benefits Pending Appeal & Reinstatement of Benefits

In certain member appeals, the Contractor will be required to continue the member's benefits pending the appeal, in accordance with 42 CFR 438.420. The Contractor must continue the member's benefits if:

- The member or provider files the appeal within ten (10) days of the Contractor mailing the notice or the intended effective date, whichever is later;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of services;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The member requests extension of benefits.

If benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the request for appeal;
- Ten (10) days pass after the Contractor has mailed the notice of an adverse decision, unless a State fair hearing and request for continuation of benefits until State hearing is resolved is requested within these ten (10) days; or
- The time period or service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the member, that is, it upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements to maintain benefits in accordance with 42 CFR 431.230 and 42 CFR 438.420. In accordance with Section 5.14.8, the Contractor shall notify the member in advance that costs may be recovered.

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

5.14.8 Member Notices of Action & Grievance, Appeal and Fair Hearing Procedures

The Contractor must provide specific information regarding member grievance, appeal, external grievance procedure (External Review by Independent Review Organization), and State fair hearing procedures and timeframes to members on a yearly basis by mail, as well as providers and subcontractors at the time they enter into a contract with the Contractor. This information shall also be included in the Member Handbook as described in Section 5.7.2. The information provided must be approved by FSSA in accordance with Section 5.8 and, as required under 42 CFR 438.10(g)(2)(xi), include the following:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- Ombudsman and independent advocacy services available as sources of advice, assistance and advocacy;
- The toll-free numbers that the member can use to file a grievance or appeal by phone;
- The fact that, if requested by the member and under certain circumstances: 1) benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and 2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member; and
- In the case of an FSSA fair hearing:
    - The right to a hearing;
    - The method for obtaining a hearing; and
    - The rules that govern representation at the hearing.

5.14.9 Member Support Services

The State shall operate or contract with a statewide Member Support Services program for the benefit of individuals in the [MLTSS program name]. The Member Support Services contractor is available to help these individuals, their informal caregivers, and families resolve questions or problems and serve as a source of assistance, advice, and advocacy.

The Contractor shall identify and dedicate specific staff to serve as contacts for the State's Member Support Services program. The Contactor shall respond directly to Member Support Services inquiries. The Contractor shall not interfere with a member's use of the Member Support Services program, including the Member Support Services contractor's involvement with member grievances and appeals.

5.15 Oral Interpretation Services

In accordance with 42 CFR 438.10(d), the Contractor shall arrange for oral interpretation services to its members free of charge for services it provides, including, but not limited to:

- Member services helpline;
- Twenty-four (24) hour nurse call line;
- Transportation;
- Assessment and stratification;
- Prevention and wellness programs(s);
- Care management;
- Complex case management; and
- Right Choices Program.

The requirement to provide oral interpretation applies to all non-English languages, and is not limited to prevalent languages discussed in Section 5.4. Oral interpretation services shall include interpretation services for the deaf and hard of hearing. The Contractor shall notify its members of the availability of these services and help them arrange them.

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

5.16 Health Equity and Cultural Competency

In accordance with 42 CFR 438.206, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Per 42 CFR 438.204, at the time of enrollment with the Contractor, the State shall provide the race, ethnicity and primary language of each member. This information shall be utilized by the Contractor to ensure the delivery of services in a culturally humble way. Furthermore, the Contractor will ensure all services are delivered through a health equity lens, meaning the Contractor is able to address barriers experienced and identified by specific populations.

Contractor shall create and submit a Health Equity and Cultural Competency plan for FSSA approval which incorporates the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS). The plan shall be reviewed by the member and informal caregiver advisory committee as described in Section 5.5 The CLAS standards are available at https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf.

The plan shall include at a minimum:

- The creation of a Health Equity and Cultural Competency Workgroup that includes the Contractor's Equity Officer, and members of the Contractor representing the diversity of the MCE's membership, including individuals with disabilities. This workgroup shall provide input to the Contractor relative to equity and cultural competency for the plan and shall be actively

involved in initiatives to reduce disparities in services and outcomes for the Contractor's membership. Individuals participating shall be compensated for their time.

- Incorporation of the CLAS enhanced standards adopted by the Department of Health and Human Services and linked to herein.
- A foundational assessment of health equity within the Contractor's membership population, including detail on inequities in accessing care in the member's setting of choice.
- A description of how the health plan will ensure that services are provided in a culturally competent and trauma-informed manner to all members so that all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, understand their condition(s) or needs, the recommended treatment(s), and the effect of the treatment or service on their condition, including side effects. See additional details set forth in Section 6.1.2 Access to Culturally and Linguistically Competent Providers.
- A description of how the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds and national origins, geographies, sexual orientations, gender identities, abilities, and religions in a manner that recognizes, affirms and respects the worth of the individual members and protects and preserves the dignity of each member.
- Identification of inequities and their root causes for the Contractor's membership including inequities that arise with certain diagnoses (such as dementia), the development of targeted interventions that are trauma informed and measures to reduce these inequities, and a description of how to evaluate progress in disparity reduction efforts will be collected and analyzed.
- The utilization of Community Health Workers as part of broader community health integration initiatives and promotion of culturally competent care.
- A training plan in equity and cultural competency for the Contractor's staff. Documentation of periodic training shall be provided in the annual assessment.

The plan shall be assessed by the Contractor annually and submitted to FSSA The assessment shall provide the outcome measures used to measure progress in the prior year, and any new interventions the Contractor will incorporate in the next year.

The MCE shall follow the guidance provided by the National Committee for Quality Assurance (NCQA) regarding the stratification of HEDIS measures by race and ethnicity.

The Contractor shall ensure that all subcontractor's services and sites are accessible and that all subcontractors are culturally competent.

5.17 Advance Directive Information

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

Written information on the Contractor's advance directive policies, including a description of applicable state law, shall be provided to members in accordance with 42 CFR 438.10(g)(2) and 42 CFR 438.3(j),

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

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

6.0 General Provider Network Requirements

The Contractor shall develop and maintain a provider network in compliance with the terms of this section, as well as Federal regulations at 42 CFR 438.68 and 438.206. In accordance with 42 CFR 438.3(l) the Contractor must allow each member to choose their health professional to the extent possible and appropriate. The Contractor shall ensure that its provider network is supported by written provider agreements, is available and physically, programmatically and geographically accessible and provides adequate numbers of facilities, physicians, pharmacies, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members. The Contractor shall also ensure that all of its contracted providers can respond to the cultural, racial and linguistic needs of its member populations. The network shall be able to handle the unique needs of its members, particularly those with special health care needs. The Contractor will be required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner.

The Contractor shall ensure all network providers are enrolled IHCP providers, consistent with the scope and application of Medicaid provider enrollment requirements set forth by FSSA. In some cases, members may receive out-of-network services. The Contractor shall encourage out-of-network providers to enroll in the IHCP, particularly emergency services providers, as well as providers based in non-traditional urgent health care settings such as retail clinics. An out-of-network provider shall be enrolled in the IHCP in order to receive payment from the Contractor. The Contractor shall be required to allow new members to receive out-of-network services if the out-of-network provider is willing to accept Medicaid reimbursement rates for continuity of care purposes. Further information about IHCP Provider Enrollment is located at: https://www.in.gov/medicaid/providers/973.htm.

FSSA requires the Contractor to develop and maintain a comprehensive network to provide services to its [MLTSS Program Name] members. The network must include providers serving special needs populations.

The Contractor shall develop a comprehensive network prior to the effective date of the Contract. The Contractor shall be required during the readiness review process to demonstrate network adequacy through the submission of GeoAccess reports in the manner and timeframe required by FSSA. The Contractor shall accept any willing HCBS provider, not inclusive of case management and service coordination, or LTSS provider for three (3) years from the effective date of the [MLTSS Program Name] contract. For all providers, the Contractor shall be required to have an open network and accept any qualified IHCP provider acting within their scope of practice until the Contractor demonstrates that it meets the access requirements. FSSA reserves the right to delay initial member enrollment in the Contractor's plan if the Contractor fails to demonstrate a complete and comprehensive network.

With approval from FSSA, Contractors that can demonstrate that they have met all access, availability and network composition requirements may require members to use in-network providers, with the exception of certain self-referral providers as described in Section 3.2. The Contractor must provide ninety (90) calendar days of advance notice to FSSA of changes to the network that may affect access,

availability and network composition. FSSA shall regularly and routinely monitor network access, availability and adequacy. FSSA shall impose remedies, as set forth in Exhibit 2, or require the Contractor to maintain an open network, if the Contractor fails to meet the network composition requirements.

In accordance with 42 CFR 438.206, the Contractor shall maintain and monitor the provider network. The Contractor shall establish written agreements with all network providers as further described in Section 6.6. In establishing and maintaining the network, the Contractor must consider the following elements:

a. The anticipated enrollment;

b. The expected utilization of services, taking into consideration the characteristics and needs of the Contractor's [MLTSS Program Name] members enrollment and anticipated enrollment;

c. The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;

d. The numbers of network providers who are not accepting new members;

e. The proximity to public transportation and/or the reliance upon non-emergency medical transportation; and

f. The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical and programmatic access for members with disabilities.

g. The ability to offer HIPAA-secure virtual/tele-health services, as appropriate.

FSSA shall assess liquidated damages as set forth in Exhibit 2 and shall impose other authorized remedies, such as requiring the Contractor to maintain an open network, for Contractor's non-compliance with the network development and network composition requirements.

The Contractor shall contract its specialist and ancillary provider network, including LTSS and HCBS providers, prior to receiving enrollment. FSSA shall have the right to implement corrective actions and shall assess liquidated damages as described in Exhibit 2 if the Contractor fails to meet and maintain the specialist and ancillary provider network access standards. FSSA shall monitor the Contractor's specialist and ancillary provider network to confirm the Contractor is maintaining the required level of access to specialty care. FSSA shall have the right to increase the number or types of required specialty providers at any time.

6.1 General Network Development and Management Plan

The Contractor shall develop and maintain a Network Development and Management Plan (NDMP) to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and which ensures the provision of covered services [42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2)].

The Contractor shall continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, quality improvement data, utilization of services, member satisfaction surveys, and demographic data requirements. The Contractor shall also develop non-financial incentive programs to increase participation in its provider network when feasible. [42 CFR 438.604(a)(5); 42 CFR 438.606; 42 CFR 438.207(b); 42 CFR 438.206]

6.1.1 LTSS Network Development and Management Plan

The Contractor shall develop and maintain a Network Development and Management Plan (NDMP) demonstrating the Contractor has adequate LTSS and HCBS provider capacity to meet the needs of each [MLTSS Program Name] member meeting Nursing Facility Level of Care (NFLOC). The Contractor shall demonstrate that they are able to serve members regardless of the county in which the member lives. Additionally, the Contractor must also meet minimum enrollee-to-provider ratios listed in the table below for each county. [42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2)].

The Contractor shall continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, utilization of services, member satisfaction surveys, and demographic data requirements. The Contractor shall also develop non-financial incentive programs to increase participation in its provider network when feasible. [42 CFR 438.604(a)(5); 42 CFR 438.606; 42 CFR 438.207(b); 42 CFR 438.206]. The Contractor shall include in the NDMP its practices for transitioning from fee-for-service to [MLTSS Program Name] and how a member's needs shall be met if services are not available in the Contractor's network.

The submission of the NDMP to the State is an assurance of the adequacy and sufficiency of the Contractor's provider network. The NDMP shall be evaluated, updated and submitted to the State annually and include the following minimum elements:

- Summary of nursing facility provider network, by county;
- Summary of HCBS provider network, including, by service and county for both the minimum of two (2) providers per county and the required enrollee to provider ratios;
- Description and demonstration of monitoring activities to ensure that LTSS-specific access standards are met;
- Demonstration of the Contractor's ongoing activities to identify each needed service, consistent with the member's service plan and the requirements of this contract, that could not be delivered due to inadequate provider capacity (service gaps). The Contractor shall document the process to analyze service gaps, identify systemic issues and implement remediation and quality improvement (QI) activities. This shall include a summary of provider network capacity issues by service and county, the Contractor's remediation, and QI activities and the targeted and actual completion dates for those activities;
- Demonstration of the Contractor's efforts to develop an expanded network of community-based residential alternatives, for enrollees of [MLTSS Program Name]. The Contractor shall report provider recruitment activities and provide a status update on capacity building; and
- Description of the Contractor's ongoing HCBS provider development activities taking into consideration identified provider capacity, network deficiencies, and service delivery issues and future growth in members needing LTSS.

Following the first quarter of implementation, the State will review all relevant reports submitted by the Contractor, including, but not limited to provider network capacity, timely service initiation capacity, timely service initiation service gaps, service utilization and continuity of care. The State will use the data provided in these reports to further establish LTSS provider capacity requirements and develop performance standards, benchmarks and associated liquidated damages for non-compliance.

6.1.2 Access to Culturally and Linguistically Competent Providers

To the extent possible, the Contractor shall provide members with access to providers who are culturally and linguistically competent in the language and culture of the member. For the purpose of this Contract, cultural and linguistic competence includes providers who serve members of different races, ethnicities, color, national origins, sexes, sexual orientations, gender identity, abilities (including members with cognitive impairments, visual impairments, hearing impairment, and/or who use sign language or an alternative mode of communication), and those with limited English proficiency. The Contractor agrees to work toward increasing the provider pool of culturally and linguistically competent providers where there is an identified need, including but not limited to, participating in state efforts to increase the provider pool of culturally and linguistically competent providers, and participating in the state's needs assessment process and related planning effort to expand the pool.

The Contractor shall develop, implement, and monitor policies that require network providers to demonstrate that they are making necessary accommodations in providing services, employing appropriate language when referring to and talking with people with disabilities, and understanding communication, transportation, scheduling, structural, and attitudinal barriers to accessing services

Nothing in this section shall obligate the Contractor to contract or continue to contract with a provider if the Contractor has determined that it has sufficient access for members to culturally and linguistically competent providers and/or if the provider does not meet the Contractor's participation criteria, including credentialing requirements.

6.2 Network Composition Requirements

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

- Serve the expected enrollment;
- Offer an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled; and
- Maintain a sufficient number, mix and geographic distribution of providers as specified below.

At the beginning of its Contract with the State, the Contractor shall submit regular network access reports as directed by FSSA. Once the Contractor demonstrates compliance with FSSA's access standards, the Contractor shall submit network access reports on an annual basis and at any time there is a significant change to the provider network (i.e., the Contractor no longer meets the network access standards). The Contractor shall comply with the policies and procedures for network access reports set forth in [MLTSS Program Name] MCE Reporting Manuals. FSSA shall have the right to expand or revise the network requirements, as it deems appropriate.

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

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

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

The Contractor shall provide FSSA written notice at least ninety (90) calendar days in advance of the Contractor's inability to maintain a sufficient network in any county. FSSA shall have the right to expand or revise the network requirements, as it deems appropriate.

For purposes of the subsections below, "urban areas" are counties not designated by the Health Resources and Service Administration (HRSA) as a rural county. "Rural areas" are those areas designated by HRSA as a rural county.

In addition to the specific Network Composition requirements listed below, the Contractor shall also meet or exceed the following:

- Contract with a minimum of 90% of IHCP enrolled acute care hospitals located in the State of Indiana.
- Contract with a minimum of 90% of IHCP enrolled Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) located in the State of Indiana.
- Contract with a minimum of 90% of IHCP enrolled Community Mental Health Centers (CMHC) located in the State of Indiana.
- Meet or exceed the following provider-to-member ratios:
    - 1:1,000 for PMPs (includes all physician and advanced practice nurses enrolled as a PMP with the Contractor)
    - 1:1,000 for Behavioral Health Providers (excluding physicians, CMHCs, and inpatient)
    - 1:2,000 for Gynecologists
    - 1:2,000 for Dentists
    - 1:5,000 for Anesthesiology, Cardiology, Endocrinology, Gastroenterology, Geriatricians, Nephrology, Ophthalmology, Orthopedic Surgery, General Surgery, Pulmonology, Rheumatology, Psychiatry, Urology, Infectious Disease, Otolaryngology, Oncology, Dermatology, and Physiatry/Rehabilitative
    - Meet or exceed the requirements and provider-to-member ratios for HCBS and LTSS services listed below.

Service Type	Requirement
Extended Facility (Skilled Nursing Facility)	1:400 and at least one facility located in each county, unless there is no facility located in a particular county

Home Health	1:150 and at least two serving each county
Hospice	1:400 and at least two serving each county
Adult Day	Contract with 90% of IHCP enrolled providers
Adult Family	Contract with 90% of IHCP enrolled providers
Assisted Living	Contract with 90% of IHCP enrolled providers
Attendant Care	1:400 and at least one provider serving each county
Service Coordination	1:300 and at least one provider serving each county
Structured Family Care	1:400 and at least one provider serving each county
Community Transitions	1:300 and at least one provider serving each county
Personal Emergency Response	1:400 and at least one provider serving each county
Integrated Healthcare Coordination	1:300 and at least one provider serving each county
Home Delivered Meals	1:200 and at least one provider serving each county
Home Modifications	1:400 and at least one provider serving each county
Home & Community Assistance	1:400 and at least one provider serving each county
Community Transportation	1:200 and at least one provider serving each county
Nutritional Supplements	1:400 and at least one provider serving each county
Pest Control	1:400 and at least one provider serving each county
Respite	1:150 and at least one provider serving each county
Specialized Medical Equipment	1:200 and at least one provider serving each county
Vehicle Modification	1:200 and at least one provider serving each county

6.2.1 Acute Care Hospital Facilities

The Contractor shall provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. The transport distance to a hospital from the member's home shall be usual and customary, not to exceed thirty (30) miles in urban areas and sixty (60) miles in rural areas. Exceptions shall be justified and documented to the State on the basis of community standards for accessing care. Inpatient services are covered when such services are prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition. FSSA strongly encourages the Contractor to contract or enter into business agreements with any acute care hospital facility that is recognized as an Age-Friendly Health System.

6.2.2 Primary Medical Providers (PMP)

Providers may contract as a PMP with one or multiple MCEs. A PMP may also participate as a specialist in another MCE. The PMP may maintain a patient base of non- [MLTSS Program Name] members (e.g., commercial, traditional Medicaid, Hoosier Care Connect, Hoosier Healthwise or HIP members). The Contractor shall not prevent the PMP from contracting with other MCEs.

The Contractor shall demonstrate compliance with 42 CFR 438.208. Specifically, the Contractor shall ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. PMPs must coordinate each member's physical and behavioral health care and make any referrals necessary. In [MLTSS Program Name], a referral from the member's PMP is required when the member receives physician services from any provider other than their PMP, unless the service is a self-referral service as set forth in Section 3.2. The PMP must agree to serve as part of each member's Interdisciplinary Care Team as set forth in Section 4.17.

The Contractor shall ensure access to PMPs within at least thirty (30) miles of the member's residence. Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, gynecologists, endocrinologists (if primarily engaged in internal medicine), geriatricians, and physician extenders as outlined in BT 201584 and in BT 201743.

The Contractor shall assess the PMP's non-[MLTSS Program Name] practice when assessing the PMP's capacity to serve the Contractor's members.

The Contractor shall have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services twenty-four (24)-hours-a day, seven (7)-days-a-week and that PMPs have a mechanism in place to offer members direct contact with their PMP, or the PMP's qualified clinical designee, through a toll-free telephone number twenty-four (24)-hours-a-day, seven (7)-days-a-week. Each PMP shall be available to see members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations. The Contractor shall also assess the PMP's non- [MLTSS Program Name] practice to ensure that the PMP's [MLTSS Program Name] population is receiving accessible services on an equal basis with the PMP's non- [MLTSS Program Name] population.

The Contractor shall ensure that the PMP provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The Contractor shall ensure that members have telephone access to their PMP (or appropriate designate such as a covering physician) in English and Spanish twenty-four (24)-hours-a-day, seven (7)-days-a-week.

The Contractor shall ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the IHCP Provider Manual. The Contractor must monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

6.2.3 Specialist and Ancillary Providers

In addition to maintaining a network of PMPs, the Contractor shall provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers. In addition, the Contractor shall have two specialist and ancillary providers listed below in each geographic region with the exception of Durable Medical Equipment and Home Health Providers.

As with PMPs, specialist and ancillary providers shall not be limited to serve in only one (1) MCE network. In addition, physicians contracted as a PMP (if applicable) with one (1) MCE may contract as a specialist with other MCEs.

The Contractor shall ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the IHCP Provider Manual. FSSA requires the Contractor to monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

FSSA requires the Contractor to develop and maintain a comprehensive network of specialty providers listed below. For providers identified with an asterisk (*), the Contractor shall provide, at a minimum, two providers for each specialty type within sixty (60) miles of the member's residence. For providers identified with two asterisks (**), the Contractor shall provide, at a minimum, one specialty provider within ninety (90) miles other member's residence.

Specialties	Ancillary Providers

• Anesthesiologists* • Cardiologists* • Cardiothoracic surgeons** • Dentists/Oral Surgeons * • Dermatologists** • Endocrinologists* • Gastroenterologists* • General surgeons* • Geriatricians** • Hematologists • Infectious disease specialists** • Interventional radiologists** • Nephrologists* • Neurologists* • Neurosurgeons** • Non-hospital based anesthesiologist (e.g., pain medicine)** • Gynecologists* • Occupational therapists* • Occupational therapists* • Oncologists* • Ophthalmologists* • Optometrists* • Orthodontists* • Orthopedic surgeons* • Orthopedists • Otolaryngologists • Pathologists** • Physical therapists* • Psychiatrists* • Pulmonologists* • Radiation oncologists** • Rheumatologists** • Speech therapists* • Urologists*	▪ Diagnostic testing* ▪ Durable and/or Specialized Medical Equipment ▪ Prosthetic suppliers**

FSSA requires that the Contractor maintain network access standards for the listed ancillary providers as follows:

- Two (2) durable medical equipment providers shall be available to provide services to the Contractor's members in each county.

Evidence that providers are trained to provide tobacco dependence treatment services must be available during FSSA's monthly onsite visits.

The Contractor shall contract with the Indiana Hemophilia and Thrombosis Center or a similar FSSA-approved, federally recognized hemophilia treatment center. The Contractor shall arrange for laboratory services only through those IHCP enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

6.2.4 Pharmacy Services

The Contractor shall establish a network of pharmacies. The Contractor or its Pharmacy Benefit Manager (PBM) must provide at least two (2) pharmacy providers within thirty (30) miles or thirty (30) minutes from a member's residence in each county, as well as at least two (2) durable medical equipment providers in each county or contiguous county.

6.2.5 Non-Psychiatrist, Non-Substance Use Disorder (SUD), and Behavioral Health Providers

In addition to the access requirements for psychiatrists as described in Section 6.2.3, the Contractor shall establish a network of behavioral health providers, addressing both mental health and addiction, experienced in treating older adults including the following:

a. Outpatient mental health and addiction clinics;
b. Community mental health centers;
c. Licensed clinical addiction counselors;
d. Licensed psychologists;
e. Health services providers in psychology (HSPPs);
f. Licensed clinical social workers;
g. Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center;
h. Licensed marital and family therapists; and
i. Licensed mental health counselors.

The Contractor is required to contract with Community Mental Health Centers (CMHC) who are certified by the Division of Mental Health and Addiction (DMHA). If all CMHCs are not included in the provider network, the Contractor shall demonstrate that this does not prevent coordination of care with MRO and 1915(i) State Plan services as required in Sections 3.20.1 and 3.20.2. Further, as described in Section 3.6.4, the Contractor shall, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs, and shall provide physical health and other medical information to the appropriate CMHC for every member.

In urban areas, the Contractor shall provide at least one (1) behavioral health provider within thirty (30) minutes or thirty (30) miles from the member's home. In rural areas, the Contractor shall provide at least one (1) behavioral health provider within forty-five (45) minutes or forty-five (45) miles from the member's home. The Contractor shall provide assertive outreach to members in rural areas where behavioral health services may be less available and shall monitor utilization to assure equality of service access and availability.

All outpatient mental health services shall be delivered by licensed psychiatrists and HSPPs, or an advanced practice nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling.

6.2.6 Inpatient Psychiatric Facilities

The Contractor shall provide a sufficient number and geographic distribution of inpatient psychiatric facilities to serve the expected enrollment. The Contractor shall contract with at least 90% of all inpatient geriatric psychiatric facilities in Indiana. The transport distance to an inpatient psychiatric facility from the member's home shall be the usual and customary, not to exceed sixty

(60) miles. Exceptions shall be justified and documented to the State on the basis of community standards for accessing care.

6.2.7 SUD Providers

The Contractor shall establish a network of SUD treatment providers that provide the continuum of the American Society of Addiction Medicine (ASAM) levels of care. These providers should provide the following levels of treatment:

- Early intervention
- Outpatient
- Intensive outpatient
- Partial hospitalization
- Clinically-managed low-intensity residential
- Clinically managed high-intensity residential
- Medically-managed inpatient

The Contractor is encouraged to contract with all available SUD treatment providers. The Contractor must include a network of providers who are authorized to provide medication-assisted treatment (MAT), including buprenorphine.

The Contractor shall ensure the availability of a MAT provider within thirty (30) miles of the member's residence.

6.2.8 Dental Providers

The Contractor shall ensure the availability of a dentist practicing in general dentistry within thirty (30) miles of the member's residence. This can include dental providers who provide service within a federally qualified health center (FQHC). Specialty dentists such as orthodontists and dental surgeons shall be available within sixty (60) miles of the member's residence.

6.2.9 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are safety net providers, FSSA strongly encourages the Contractor to contract with FQHCs and RHCs that meet all of the Contractor's requirements regarding the ability of these providers to provide quality services. The Contractor shall reimburse FQHCs and RHCs for services at no less than the level and amount of payment that the Contractor would make to a non-FQHC or non-RHC provider for the same services. In accordance with section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), the Contractor shall pay any out-of-network Indian healthcare provider (see Section 6.2.10) that is a FQHC for covered services provided to an American Indian/Alaska Native member at a rate equal to the amount of payment that the Contractor would pay to an in-network FQHC that is not an Indian health care provider for the same services.

In accordance with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), FSSA shall make supplemental payments to FQHCs and RHCs that subcontract (directly or indirectly) with the Contractor. These supplemental payments represent the difference, if any, between the payment to which the FQHC or RHC would be entitled for covered services under the Medicaid provisions of BIPA and the payments made by the Contractor.

FSSA requires the Contractor to identify any performance incentives it offers to the FQHC or RHC. FSSA shall review and must approve any performance incentives. The Contractor shall

report all such FQHC and RHC incentives which accrue during the Contract period related to the cost of providing FQHC-covered or RHC-covered services to its members along with any fee-for-service and/or capitation payments in the determination of the amount of direct reimbursement paid by the Contractor to the FQHC or RHC. If the incentives vary between the Contractor's [MLTSS Program Name] lines of business, the Contractor shall so specify in its reporting to FSSA.

The Contractor shall perform quarterly claim reconciliation with each contracted FQHC or RHC to identify and resolve any billing issues that may impact the clinic's annual reconciliation conducted by FSSA.

FSSA requires the Contractor to provide the Contractor's utilization and reimbursement data for each FQHC and RHC in each month of the reporting period. The report shall be completed in the form and manner set forth in the MCE Reporting Manual, which is updated annually.

The submitted FQHC and RHC data must be accurate and complete. The Contractor shall pull the data by NPI or LPI, rather than other means, such as a Federal Tax ID number. The Contractor shall establish a process for validating the completeness and accuracy of the data, and a description of this process shall be available to FSSA upon request. The claims files should not omit claims for practitioners rendering services at the clinic nor should the files contain claims for practitioners who did not practice at the clinic.

In addition, FSSA requires the FQHC or RHC and the Contractor to maintain and submit records documenting the number and types of valid encounters provided to members each month. Capitated FQHCs and RHCs shall also submit encounter data (e.g., in the form of shadow claims to the Contractor) each month. The number of encounters will be subject to audit by FSSA or its representatives.

The Contractor shall work with each FQHC and RHC in assisting FSSA and/or its designee in the resolution of disputes concerning year-end reconciliations between the federally required interim payments (made by FSSA to each FQHC and RHC on the basis of provider reported encounter activity) and the final accounting that is based on the actual encounter data provided by the Contractor.

6.2.10 Indian Healthcare Providers

Section 5006 of ARRA provides certain protections for Indian health care providers in Medicaid. An Indian health care provider means a health care program, including providers of contract health services, operated by the Indian Health Service (IHS) or an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). The Contractor shall offer to enter into contracts with Indian health care providers participating in Medicaid that reflect the provisions in this Section.

6.2.10.1 Access to Indian Healthcare Providers

In accordance with section 5006(d) of ARRA, the Contractor shall:

- Permit any American Indian or Alaska Native (AI/AN) enrollee who is eligible to receive services from a participating Indian healthcare provider to choose to receive covered services from that Indian healthcare provider, and if that Indian healthcare provider participates in the network as a PMP (if applicable), to choose that Indian healthcare provider as their PMP, as long as that Indian healthcare provider has the capacity to provide the service;
- Demonstrate that there are sufficient Indian healthcare providers in the Contractor's network to ensure timely access to services available under the Contract for AI/AN enrollees who are eligible to receive services from such providers. The Contractor shall be held to standards issued by CMS regarding

sufficiency of Indian healthcare providers in states like Indiana where few Indian healthcare providers are available. In accordance with 42 CFR §438.56(c) and §457.1212, in the event that timely access to Indian healthcare providers in network cannot be guaranteed due to few or no network participating Indian healthcare providers, the sufficiency standard is satisfied if:

- AI/AN enrollees, living on or off tribal lands, are permitted by the Contractor, to access out-of-state Indian healthcare providers; or
- This circumstance is deemed a good cause reason under the managed care plan contract for AI/AN enrollees to disenroll from the managed care program into fee-for-service.

In accordance with 42 CFR §438.14(b)(3):

The Contractor shall not require any Service Authorization or impose any condition for an AI/AN enrollee to access services at such facilities. This includes the right of the AI/AN enrollee to choose an Indian Healthcare Provider as a Primary Care Provider, if the Indian Healthcare Provider is a network Provider.

6.2.10.2 Referrals from Indian Healthcare Providers
When a physician in an Indian Healthcare facility refers an AI/AN enrollee to a Network Provider for services covered under this Contract, the Contractor shall not require the member to see a Primary Care Provider prior to the referral.

The network Provider to whom the Indian Healthcare physician refers the member may determine that services are not Medically Necessary or not covered.

6.2.10.3 Tribal Assessments and Care Plans

The Contractor will accept the results of home care service assessments, waiver assessments, reassessments and the resulting care plans developed by tribal assessors for AI/AN enrollees as determined by the tribe. Referrals to non-tribal providers for services resulting from the assessments must be made to providers within the Contractor's network. This applies to services requested by AI/AN enrollees residing on or off tribal land.

6.2.10.4 Tribal Training and Orientation
The Contractor shall provide training and orientation materials to tribal governments upon request and shall make available training and orientation for any interested tribal governments.

6.2.10.5 Payment for Indian Healthcare Providers
In accordance with section 5006(d) of ARRA, the Contractor shall:

i. Reimburse Indian healthcare providers, whether in-or out-of-network, for covered services provided to AI/AN enrollees who are eligible to receive services from such providers either at a rate negotiated between the Contractor and the Indian healthcare provider, or if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the services were provided by an in-network provider that is not an Indian healthcare provider.

ii. Make prompt payment to all Indian healthcare providers as set forth in Section 9.7.3; and

iii. Not reduce payments to Indian healthcare providers, or other providers of contract health services under referral by an Indian healthcare provider, for

covered services provided to an AI/AN enrollee by the amount of a copayment or other cost-sharing that would be due from the AI/AN enrollee if not otherwise prohibited under Section 5006(a) of ARRA.

Section 5006(d) of ARRA requires that the State provide a supplemental payment to non-FQHC Indian healthcare providers for covered services provided to AI/AN enrollees. The amount of the supplemental payment is the difference, if any, of the rate paid by the Contractor for the services and the rate that applies to the provision of such services under the State Plan, which is the encounter rate determined by IHS in the annual federal register notice. To the extent FSSA requires utilization and/or reimbursement data from the Contractor to make a supplemental payment to an Indian healthcare provider, the Contractor shall provide the requested data within thirty (30) calendar days of the request.

6.2.10.6 Cooperation
The Contractor agrees to work cooperatively with the State, other MCEs under contract with the State, and tribal governments to find mutually agreeable mechanisms to implement this section including, but not limited to, a common notification form by which tribal governments may report referrals to the Contractor.

6.2.11 County Health Departments

FSSA strongly encourages the Contractor to contract or enter into business agreements with any health departments that are willing to coordinate with the Contractor and are able to meet the Contractor's credentialing and service delivery requirements.

6.2.12 Urgent Care Clinics

The Contractor shall affiliate or contract with urgent care clinics. In addition, the State strongly encourages the Contractor to affiliate or contract with non-traditional urgent care clinics, including retail clinics. The State will continue to monitor the Contractor's access to primary and urgent care during readiness review and throughout the Contract term. Urgent care clinics shall be made available no less than eleven (11) hours each day Monday through Friday and no less than five (5) hours each day on the weekend.

6.2.13 Dialysis Treatment Center

The Contractor shall ensure the availability of one dialysis treatment center within sixty (60) miles of the member's residence. The Contractor shall prioritize the transportation of members to dialysis when scheduling non-emergent medical transport.

6.2.14 Gynecologists

The Contactor shall establish a network of gynecologists for women's healthcare needs. The Contractor shall ensure the availability of at least two (2) gynecologists practicing within sixty (60) miles of the member's residence and at least one (1) gynecologist practicing within thirty (30) miles of the member's residence. FSSA reserves the right to change this requirement at any time in accordance with Section 2.13 Future Program Guidance.

6.2.15 Non-Emergency Medical Transportation Providers

In accordance with 42 CFR 440.170 the Contractor shall provide an appropriate means of NEMT for individuals, who have no other means of transportation available, and addresses the safety needs of the person with disabilities and/or special needs.

6.2.16 Physician Extenders

Physician extenders are health care professionals who are licensed to practice medicine under the supervision of a physician. Physician extenders can perform some of the services that physicians provide, such as physical exams, preventive health care and education. Some can also assist in surgery and write prescriptions.

According to Indiana law, the following physician extenders are licensed to provide care in Indiana:

- Advanced practice nurses, including nurse practitioners, nurse midwives and clinical nurse specialists;
- Physician assistants; and
- Certified registered nurse anesthetists.

State Medicaid programs are required to make nurse practitioner services available to Medicaid recipients in accordance with 42 CFR 441.22. The Contractor shall permit members to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the Contractor's network. The Contractor shall have the capability to add certain physician extenders to their networks to be credentialed and contracted as primary care providers should OMPP authorize said physician extenders to participate as primary care providers moving forward.

6.2.17 Skilled Nursing Facilities

The Contractor must maintain the adequacy of its Provider Network sufficient to provide Enrollees with reasonable choice within each county of the Contracting Area, provided that each Network Provider meets all applicable State and federal requirements for participation in the Program. For the first three (3) years of the program, the Contractor shall accept into their network any skilled nursing facility that agrees to the Contractor's standard provider agreement and meets all applicable State and Federal participation requirements.

6.2.18 LTSS Providers

For Providers of each of the LTSS Covered Services identified in Section 3.0, the Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area. For the first three (3) years of the program, the Contractor shall accept into their network any LTSS or HCBS provider that agrees to the Contractor's standard provider agreement and meets all applicable State and Federal participation requirements.

6.2.19 Telehealth

Telehealth is defined as healthcare services delivered via asynchronous (store and forward), remote patient monitoring, teledentistry, or telehealth (interactive audio and video). The Contractor shall promote the use of telehealth to support an adequate provider network. Telehealth shall not replace provider choice and/or member preference for physical delivery of services. The Contractor shall be responsible for the oversight, administration, and implementation of telehealth services in compliance with State and Federal laws, guidance, and the requirements of this Contract and all incorporated references. The Contractor shall ensure that telehealth is available and utilized, when appropriate, to ensure geographic accessibility of services to members. The Contractor shall be responsible for developing and expanding the use and availability of telehealth services, when indicated and appropriate.

6.2.20 Remote Technology

Remote patient monitoring (RPM) is a method of healthcare delivery that uses the latest advances in information technology to gather patient data outside of traditional healthcare settings. The Contractor is encouraged to leverage RPM to maximize appropriate care strategies, empower self-direction, extend capacity and expand access to services.

6.3 Workforce Development

The Contractor shall have a program to monitor and assess current workforce capacity and capability, forecast and plan future workforce capacities and capabilities and when indicated, deliver technical assistance to provider organizations to strengthen their workforce development programs. The Contractor shall develop and implement a workforce development strategy that is consistent with and complementary to FSSA's workforce plan and make that plan available to the public. The Contractor shall conduct efforts in support of FSSA's workforce plan.

The Contractor shall collaborate with FSSA and other agencies on any workforce development activities. The Contractor shall develop and deploy data collection and information processing resources for assessing the current level of workforce capacity and capability strengths and deficits as well as forecasting and planning strategies that address future workforce requirements.

The State reserves the right to include workforce development related measures as part of the program Pay for Performance stipulated in Exhibit 2.

6.4 Provider Accessibility

The Contractor shall implement policies and procedures related to network provider accessibility as required below. These policies and procedures shall be submitted to the State for review and approval.

- Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.
- Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week when medically necessary.
- The Contractor shall require its network providers to meet standards for timely access to care and services, taking into account the urgency of the need for services as required herein.
- Urgent care appointments for physical or behavioral illness injuries that require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services): Appointments within twenty-four (24) hours.
- Routine care with physical or behavioral symptoms (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever): Appointments within one (1) week or five (5) business days whichever is earlier.
- Routine care without physical or behavioral symptoms (e.g. routine physical exams): Appointments within thirty (30) calendar days.
- Aftercare appointments within seven (7) calendar days after hospital discharge
- For durable medical equipment (excluding hearing aids, prosthetics, and family planning supplies), no more than thirty (30) business days from the time of service order. For highly specialized equipment and supplies, no more than one hundred and twenty (120) business days from the time of service order.

- For environmental accessibility adaptations (home modifications), no more than ninety (90) business days from time of service approval.
- Consultative clinical and therapeutic services for informal caregivers, no more than sixty (60) business days from time of service approval.
- The health plan shall have policies and procedures in accordance with these appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The health plan shall disseminate these appointment standard policies and procedures to its in-network providers and to its members. The health plan shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.

6.5 Provider Qualifications and Standards

The Contractor shall ensure HCBS LTSS providers meet the Division of Aging provider qualification requirements set out in 455 IAC 1-3 and in the IHCP provider manual.

6.6 Provider Enrollment and Disenrollment

The Contractor shall be responsible for meeting all provider screening and enrollment requirements described in 42 CFR 455 Subpart E. The Contractor is prohibited from contracting with providers who have been excluded or have had owners or operators (i.e., those with a controlling interest) excluded by the Federal Government or by the State's Medicaid program for fraud, abuse or neglect. The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any services provided by excluded individuals shall be refunded to and/or obtained by the State and/or the Contractor as prescribed in section 8.4 Program Integrity Overpayment Recovery. Where the excluded individual is the provider of services or an owner of the provider, all amounts paid to the provider for services rendered following their exclusion shall be refunded. The Contractor shall be responsible for checking the lists of providers currently excluded by the State and the Federal Government every thirty (30) calendar days. The Contractor shall capture ownership and control information from its providers required under 42 CFR 455, including 42 CFR 455.104. In addition, the Contractor shall also maintain a list of all rendering providers of providers enrolled, even if rendering providers are not required to enroll with IHCP. Rendering providers are defined as those providers that are performing the services for which a provider bills the Contractor or IHCP. The federal list is available at: http://exclusions.oig.hhs.gov. FSSA reserves the right to immediately disenroll any provider if the provider becomes ineligible to participate in the Program. The Contractor shall immediately inform the OMPP Program Integrity Unit via a written communication should it disenroll, terminate or deny provider enrollment or credentialing for “program integrity” reasons (i.e., the detection and investigation of fraud and abuse).

The Contractor shall follow established procedures to enroll and disenroll providers, including PMPs. The [MLTSS Program Name] MCE Policies and Procedures Manual provides detailed information on PMP and provider enrollment and disenrollment procedures.

To process provider enrollments and disenrollments with the Contractor, the Contractor shall submit the required information to the State fiscal agent through the Portal.

The Contractor shall report PMP disenrollments to the State fiscal agent’s Provider Enrollment unit by mail, fax, e-mail or Portal. The Contractor shall first notify the State fiscal agent of the intent to disenroll a PMP within five (5) business days of the receipt/issuance of the PMP’s disenrollment. The fiscal agent shall receive enrollment/disenrollment requests at least five (5) business days prior to the 24th day of the month before the date the Contractor desires the enrollment or disenrollment to become effective. As noted above, the OMPP PI Unit should also receive disenrollment notices when they are program

integrity related. When advanced notice is not feasible, including, but not limited to, in the event of provider death or exclusion due to fraud or abuse, the Contractor shall submit the disenrollment within five (5) business days of the provider's termination effective date. OMPP shall have the right to take corrective actions if the Contractor does not notify the State fiscal agent in a timely manner.

OMPP shall have the right to immediately disenroll any provider if the provider including the provider's rendering providers – or provider's owners/operators becomes ineligible to participate in IHCP.

When a PMP disenrolls from the Program, the Contractor shall be responsible for assisting members assigned to that PMP in selecting a new PMP within the Contractor's network. If the member does not select another PMP, the Contractor shall assign the member to another PMP in the Contractor's network before the original PMP's disenrollment is effective.

The Contractor shall provide the IHCP MCE Practitioner Enrollment Form, IHCP MCE Hospital/Ancillary Provider Enrollment Form or a Contractor specific Network Participation Request Form to providers to complete when requesting to join the Contractor's network. If a Contractor Network Participation Request Form is utilized, it shall include all the information captured on the IHCP MCE Enrollment Forms.

The Contractor shall follow the OMPP network effective date policy for all network participation requests. Providers will be effective with the Contractor on the first of the month following the receipt of a complete network participation request. This effective date policy should be followed for all provider types and for all delegated provider networks. Providers must be fully enrolled and effective as an IHCP provider prior to becoming effective with the Contractor. The [MLTSS Program Name] MCE Policies and Procedures Manual provides detailed information on the provider effective date policy.

Providers that will be delivering HCBS services must meet Division of Aging (DA) provider criteria and be certified by the DA before they can serve [MLTSS Program Name] enrollees. The Contractor will receive a list of qualified providers from FSSA to begin contracting processes. HCBS providers will start enrollment with the fiscal agent to be an IHCP provider, then work with MCEs to be contracted.

The Contractor shall have a central repository solution for all documentation and correspondence that is related to and occurs during the provider network participation process. Contractors must retain the request for participation form, all supporting documents submitted by the provider, all credentialing files, and contract related documents as well as written and email correspondence in the repository.

The Contractor shall conduct an annual internal review of the network participation process and determine if there are key inefficiencies that need to be addressed. This includes a review of all components of the provider network participation process and timeliness to complete provider requests.

6.6.1 Provider Network Change Procedures

The Contractor must provide ninety (90) calendar day advance notice to FSSA of changes to the network that may affect access, availability and network composition. FSSA shall regularly and routinely monitor network access, availability and adequacy. FSSA shall impose remedies, as set forth in Exhibit 2, The notice shall be issued in advance of the PMP change when possible or as soon as the MCE becomes aware of the circumstances necessitating a change.

6.6.1.1 PMP Termination

In accordance with 42 CFR 438.10(f), the Contractor shall make a good faith effort to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis. Such notice shall be provided to members at least thirty (30) calendar days prior to the effective date of the termination. However, if the practice or practitioner notifies the Contractor less than thirty (30) days prior to the effective date of the termination, the Contractor shall then notify members as soon as possible but no later than fifteen (15)

calendar days after receipt of the notification from the practice or practitioner The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the MCE, the provider moves from the service area and fails to notify the Contractor or a provider fails credentialing, and instead shall be made immediately upon the Contractor becoming aware of the circumstances.

6.6.1.2 Member Notice Requirements
The Contractor must ensure that all enrollee notices are written and issued in adherence with applicable state and federal regulations and the requirements in Section 5 regarding the notice content, timing, format, readability, and language requirements set forth in 42 C.F.R. §438.10 and §438.404.

6.6.1.3 Change in PMP
The Contractor shall immediately provide written notice to a member when the MCE changes the member's PMP. The notice shall be issued in advance of the PMP change when possible or as soon as the Contractor becomes aware of the circumstances necessitating a change.

6.6.1.4 Physical Health or Behavioral Health Providers Providing Ongoing Treatment Termination
If a member is in a prior authorized ongoing course of treatment with any other contract provider who becomes unavailable to continue to provide services to such member and the MCE is aware of such ongoing course of treatment, the MCE shall provide written notice to each member as soon as possible but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the Contractor, the provider moves from the service area and fails to notify the MCE or a provider fails credentialing, and instead shall be made immediately upon the MCE becoming aware of the circumstances.

6.6.1.5 Non-PMP Provider Termination
If a non-PMP provider, including but not limited to a specialist or hospital, ceases participation in the MCE, the MCE shall provide written notice to members who have been seen and/or treated by the non-PMP provider within the last six (6) months. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the PMP becoming aware of the termination.

6.6.1.6 LTSS Provider Termination
If an LTSS provider ceases participation in the MCE, the Contractor shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or is authorized to receive LTSS services from that provider. Notices regarding termination by a facility shall comply with state and federal requirements. The requirement in this section to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the MCE the provider moves from the service area and fails to notify the Contractor or a provider fails credentialing, and instead shall be made immediately upon the Contractor becoming aware of the circumstances. In their contracts with LTSS

providers the Contractor shall require LTSS providers to adhere to the transition requirements in 455 IAC 2-8-4. See 4.12 Transitions regarding requirements for transitioning from a terminating provider to a new provider.

6.6.1.7 Network Deficiency
Upon notification from FSSA that a corrective action plan designed to remedy a network deficiency has not been accepted, the MCE shall immediately provide written notice to members living in the affected area of a provider shortage in the Contractor's network.

6.6.1.8 Hospital Termination
Termination of the Contractor's provider agreement with any hospital, whether or not the termination is initiated by the hospital or by the Contractor, shall be reported by the Contractor in writing to the FSSA no less than thirty (30) calendar days prior to the effective date of the termination.

6.6.1.9 Other Provider Terminations
The Contractor shall notify the FSSA of any provider termination and shall submit an Excel spreadsheet that includes the provider's name, IHCP provider identification number, NPI number, and the number of members affected within five (5) business days of the provider's termination. If the termination was initiated by the provider, the notice to FSSA shall include a copy of the provider's notification to the Contractor. The Contractor shall maintain documentation of all information, including a copy of the actual member notice(s), on-site. Upon request, the Contractor shall provide FSSA a copy of the following: one or more of the actual member notices mailed, an electronic listing in Excel identifying each member to whom a notice was sent, a transition plan for the members affected, and documentation from the Contractor's mail room or outside vendor indicating the quantity and date member notices were mailed as proof of compliance with the member notification requirements.

6.6.1.10 Compliance
If termination of the Contractor's provider agreement with any provider, whether or not the termination is initiated by the provider or by the Contractor, places the Contractor out of compliance with the network requirements, the Contractor shall provide a written plan to come into compliance and shall submit GeoAccess reports in the manner and timeframe required by the FSSA.

6.7 Provider Credentialing

The Contractor shall have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current state licensure and enrollment in the IHCP. The Contractor's credentialing and re-credentialing process for all contracted providers, excluding HCBS providers, shall meet the National Committee for Quality Assurance (NCQA) guidelines. The same provider credentialing standards must apply across all Indiana Medicaid programs.

For HCBS providers, the Contract shall not conduct a traditional NCQA credentialing process. Instead, the Contractor may review the provider's compliance with contractual requirements and the provider's eligibility to participate in the program (IHCP enrollment, etc.).

The State encourages the MCEs to make credentialing as streamlined and simple as possible for medical providers. The Contractor shall use the information outlined on IHCP MCE Practitioner Enrollment Form and IHCP MCE Hospital/Ancillary Provider Enrollment Forms during the credentialing process. The Contractor must ensure that providers agree to meet all of FSSA's and the Contractor's standards for credentialing PMPs and specialists, and maintain IHCP manual standards, including:

- Compliance with state record keeping requirements;

- FSSA's access and availability standards; and
- Other quality improvement program standards.

As provided in 42 CFR 438.214(c), the Contractor's provider credentialing and selection policies shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor shall not employ or contract with providers that have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act. The Contractor shall notify FSSA, in the manner prescribed by the State, of any credentialing applications that are denied due to program integrity related reasons.

The Contractor shall process all credentialing applications within thirty (30) calendar days of receipt of a complete application. If the Contractor delegates credentialing functions to a delegated credentialing agency, the Contractor shall ensure all credentialed providers are loaded into the Contractor's provider files and claims system within fifteen (15) calendar days of receipt from the delegated entity.

The Contractor shall outline for providers the information necessary and steps required to be credentialed with the Contractor, including what provider types require credentialing and which do not. This information should be communicated on the Contractor's public facing website and in direct correspondence with providers.

Additionally, the Contractor shall provide a portal for providers seeking credentialing that will allow the provider to communicate with the MCE, submit their credentialing documentation, and to see the status of their credentialing process.

The contractors credentialing and recredentialing process, policies and procedures must be demonstrated in readiness review.

6.8 Provider Referrals

The Contractor is required to make arrangements with or referrals to, a sufficient number of qualified physicians, facilities, and Home and Community Based Service and social support providers to ensure that the services under the contract can be furnished promptly and without compromising the quality of care in accordance with 42 CFR 438.3(q)(1) and 42 CFR 438.3(q)(3). In addition to the requirements pertaining to referrals as described throughout this contract, the Contractor shall have adequate written policies and procedures regarding referrals to specialists and provide education to members and/or providers regarding referral procedures, to include, at a minimum, the following:

a. The use of the Contractor's referral process
b. Targeted education and training to ensure that primary care providers, other physical health providers and LTSS providers know the process to refer members to specialists and specifically behavioral health services;
c. Targeted education to ensure behavioral health providers know the process to refer members to physical health services;
d. Requirements for intake in order to ensure member access to behavioral health services;
e. Process and requirements in place that ensures the member's Primary Medical Provider receives all specialist and consulting reports;
f. Referral processes offered through the Contractor helpline staff;
g. Referral training for Care management and other appropriate Contractor staff including how the Contractor will notify the member if the referral is to a provider owned by the Contractor;
h. Process for providers to refer members to the Contractor's care management program or to receive HCBS and other LTSS supports.
i. Process to ensure the Primary Medical Provider follow-up of referrals for behavioral health services; and

j. A referral plan for any member who is about to lose eligibility and who requests information on low-cost or no-cost health care services.

The MCE may not require a referral from a member's PMP for the member to obtain medical services from within the MCEs network or an out of network self-referral provider. This does not prohibit an MCE from requiring authorization on specific medical services.

6.9 Provider Agreements

The Contractor must have a process in place to review and authorize all network provider contracts. The Contractor must submit a model or sample contract of each type of provider agreement to OMPP for review and approval at least sixty (60) calendar days prior to the Contractor's intended use. The Contractor must notify OMPP of any changes to the sample contracts within three (3) weeks of the Contract award date. In additional to traditional medical provider agreements, the Contractor shall maintain a specific model contract to be used with HCBS providers particularly designed for their unique needs.

The Contractor shall include in all of its provider agreements provisions to ensure the continuation of benefits. The Contractor shall identify and incorporate the applicable terms of its Contract with the State and any incorporated documents. Under the terms of the provider services agreement, the provider shall agree that the applicable terms and conditions set out in the Contract, any incorporated documents, and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members. The requirement set forth in Section 2.9 that subcontractors indemnify and hold harmless the State of Indiana does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

In addition to the applicable requirements for subcontracts in Section 2.9, the provider agreements shall meet the following requirements:

- Describe a written provider claim dispute resolution process.

- Require each provider to maintain a current IHCP provider agreement and to be duly licensed in accordance with the appropriate state licensing board and remain in good standing with said board, when applicable.

- Require each provider to submit all claims that do not involve a third-party payer for services rendered to the Contractor's members within ninety (90) calendar days or less from the date of service. The Contractor shall waive the timely filing requirement in the case of claims for members with retroactive coverage.

- Allow each provider to utilize the Indiana Health Coverage Program Prior Authorization Request Form available on the Indiana Medicaid website for submission of prior authorization requests to the Contractor.

- Include a termination clause stipulating that the Contractor shall terminate its contractual relationship with the provider as soon as the Contractor has knowledge that the provider's license or IHCP provider agreement has terminated.

- Terminate the provider's agreement to serve the Contractor's Program members at the end of the Contract with the State.

- Monitor providers and apply corrective actions for those who are out of compliance with FSSA's or the Contractor's standards.

- Obligate the terminating provider to submit all encounter claims for services rendered to the Contractor's members while serving as the Contractor's network provider and provide or reference the Contractor's technical specifications for the submission of such encounter data.

- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors.

- Provide the PMP with the option to terminate the agreement without cause with advance notice to the Contractor. Said advance notice shall not have to be more that ninety (90) calendar days.

- Provide a copy of a member's medical record at no charge upon reasonable request by the member, and facilitate the transfer of the member's medical record to another provider at the member's request.

- Require each provider to agree that it shall not seek payment from the State for any service rendered to a Program member under the agreement.

- For behavioral health providers, require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven (7) calendar days from the date of the member's discharge.

The Contractor shall have written policies and procedures for registering and responding to claims disputes for out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6-1.

6.10 Medical Records

The Contractor shall assure that its records and those of its participating providers document all medical services that the member receives in accordance with state and federal law. In accordance with 405 IAC 1-1.4-2, the provider's medical record shall include, at a minimum:

- The identity of the individual to whom service was rendered;

- The identity of the provider rendering the service;

- The identity, including date signature or initials, and position of the provider employee rendering the service, if applicable;

- The date on which the service was rendered;

- The diagnosis of the medical condition of the individual to whom service was rendered; relevant to physicians, optometrists, and dentists only;

- A detailed statement describing services rendered, including duration of services rendered;

- The location at which services were rendered;

- The amount claimed through Medicaid for each specific service rendered;

- Written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document the acute medical needs, excluding HCBS services;

- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment and ongoing evaluations as to assess progress and refine goals, if applicable (for example: pest control and home modification would not require a treatment plan) and

- X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imaging records.

The Contractor's providers must maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. [42 CFR 438.208(b)(5)] Medical records shall be legible, signed (manually or electronically) and dated and maintained for at least seven (7) years as required by state and federal regulations.

The Contractor's providers shall provide a copy of a member's medical record upon reasonable request by the member at no charge. [42 CFR 438.100(b)(2)(vi)] The provider shall facilitate the transfer of the member's medical record to another provider at the member's request. The Contractor shall ensure that providers maintain and share a member health record in accordance with professional standards [42 CFR 438.208(b)(5)].

Confidentiality of, and access to, medical records shall be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal requirements, including, but not limited to, 42 CFR Part 2 specific to the confidentiality of alcohol and drug abuse records. See section 2.10 for more information regarding the confidentiality of member medical records.

The Contractor's providers shall permit the Contractor and representatives of FSSA to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason, in accordance with 405 IAC 1-1.4-2. The failure of Contractor and/or its participating providers to keep and maintain detailed and accurate medical records as required in this section may result in Contractor and/or its participating providers repaying FSSA or Contractor for amounts paid corresponding to the services rendered for which accurate and detailed medical records are not timely provided.

Records must be provided by Contractor and/or its participating providers upon request within the timeframe identified in the request. FSSA in its sole discretion may authorize additional time for responding to medical records requests made by the Contractor or FSSA. The failure of the Contractor and/or its participating providers to submit records in a timely manner may result in the assessment of an overpayment and/or other non-compliance remedies identified in Exhibit 2. FSSA encourages Contractors to use technology, including participation in health information exchanges, where appropriate to transmit and store medical record data. See Section 9.6 for more information regarding electronic health records and data sharing requirements.

6.11 Provider Education and Outreach

The Contractor shall provide ongoing education to the provider network on the program as well as Contractor-specific policies and procedures. The Contractor shall develop an education and training workplan for contracted providers regarding key requirements of this Contract and the specific training requirements for providers of LTSS s as specified in this section. The education and training workplan shall be submitted annually to FSSA as further described in the Reporting Manual. In addition to developing its own provider education and outreach materials, the Contractor shall be required to coordinate with FSSA-sponsored provider outreach activities upon request.

Education and training regarding the Contractor-specific policies and procedures shall occur for providers of LTSS no later than thirty (30) days prior to implementation of this Contract and ongoing upon initial provider contracting. The Contractor shall offer education and training regarding the Contractor-specific policies and procedures for all contracted providers regarding provider requirements and responsibilities, the Contractor's prior authorization policies and procedures, clinical protocols,

caring for populations at greater risk for negative health outcomes, aging populations, person-centered standards, member's rights and responsibilities, claims submission process, claims dispute resolution process, pay-for-outcomes programs and any other information relevant to improving the services provided to the Contractor's members and as described in the Provider Policy and Procedure Manual and Section 6.11.2.

The Contractor will ensure that providers of long-term services and supports maintain a level of training appropriate to the services that they provide. The Contractor will identify areas where the need for further provider training is evident and share information with providers about available resources and training. Contractors shall ensure that providers have access to training programs. Contractors shall specifically assess and/or provide resources and training programs to train all long-term services and supports personnel in the prevention and detection of all forms of abuse and neglect and to assist professionals and informal caregivers to prevent and manage stress and burnout, person-centered thinking, and 42 CFR 441.301(c) settings rule compliance as applicable.

As described in Section 2.12, the Contractor shall notify the State of material changes that may affect provider procedures at least thirty (30) calendar days prior to notifying its provider network of the changes. The Contractor shall give providers at least forty-five (45) calendar days advance notice of material changes that may affect the providers' procedures such as changes in subcontractors, claims submission procedures or prior authorization policies. The Contractor must post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

In accordance with 42 CFR 438.102, the Contractor cannot prohibit or otherwise restrict a health care professional from acting within the scope of their practice and advising or advocating on behalf of a member. Contractor communications should communicate this clearly to all providers.

6.11.1 Provider Communications Review and Approval

All provider communication materials required in this section or otherwise developed by the Contractor shall be pre-approved by FSSA. The Contractor shall develop and include a Contractor-designated inventory control number on all provider communications, including letters, forms, bulletins and promotional, educational, training, informational or other outreach materials, with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate FSSA's review and approval of all provider communications and documentation of its receipt and approval of original and revised documents.

The Contractor shall submit all provider communication materials designed for distribution to, or use by, contracted providers to FSSA for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor shall also submit any material changes to previously approved provider communication materials to FSSA for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor shall receive approval from FSSA prior to distribution or use of materials. FSSA's decision regarding any communication materials is final. The Contractor shall include the State program logo(s) in their provider communication materials upon OMPP request.

The Contractor shall not refer to or use the FSSA, OMPP, or other state agency name or logo in its provider communications without prior written approval. The Contractor shall request in writing approval from OMPP for each desired reference or use at least thirty (30) calendar days prior to the reference or use. Any approval given for the FSSA, OMPP, or other state agency name or logo is specific to the use requested and shall not be interpreted as blanket approval.

All FSSA-approved provider communication materials shall be available on the Contractor's provider website within three (3) business days of distribution. The provider communication materials shall be organized online in a user-friendly, searchable format by communication type and subject.

Any provider communications by a subcontractor to IHCP providers must comply with the provisions in the section, just as the contractor is required.

6.11.2 Provider Policy and Procedures Manual

The Contractor shall provide and maintain a Provider Policies and Procedures Manual for use by the Contractor's network of providers. The Provider Policies and Procedures Manual shall be available both electronically and in hard copy (upon request) to all network providers, without cost, when they are initially enrolled, when there are any changes in policies and procedures, and upon a provider's request. The Provider Policies and Procedures Manual shall include, at minimum, the following information, separately stated for each State line of business as appropriate:

1. Description of Indiana Medicaid program and resources including information or services available through Medicaid website (e.g. provider registration and/or other portals);
2. Member eligibility verification instructions;
3. Information on Contractor organization/administrative structure;
4. Contractor, FSSA and OMPP contact information such as addresses and phone numbers;
5. Benefits and limitations;
6. Claims filing instructions;
7. Criteria and process to use when requesting prior authorizations;
8. Definition and requirements pertaining to urgent and emergent care;
9. Members' rights;
10. Providers' rights for advising or advocating on behalf of their patient in accordance with CFR 42.438.102;
11. Provider responsibility and the Contractor's expectation of the Provider;
12. Provider non-discrimination information;
13. Policies and procedures for grievances and appeals in accordance with 42 CFR 438.414;
14. Expected response times for provider inquiries (telephone contacts, letters, emails, faxes);
15. Contractor policies and procedures relevant to providers regarding procedures for identifying provider locations that provide physical access, accessible equipment, and/or reasonable accommodations for members with physical or cognitive disabilities;
16. Other significant Contractor policies affecting providers such as nursing facility and HCBS setting contract termination procedures;
17. TPL and/or coordination of benefits policy;
18. Member cost sharing requirements;
19. Medical record standards;
20. Credentialing and re-credentialing activities;
21. Claims medical review; medical necessity standards and clinical practice guidelines;
22. Coordination and/or transition of care responsibilities;
23. Needs assessment and/ service planning requirements;
24. Information on how members may access specialists;
25. Person-centered thinking and cultural competency information including accessing interpretation services to assist members who speak another language;
26. Specific policy for drug, alcohol and/or behavioral health treatment availability and referral processes;
27. Formulary and exception process information;
28. Missed appointment and follow-up responsibilities;
29. Fraud, waste, and abuse responsibilities;
30. Frequently asked questions and answers;
31. Appointment standards;
32. Encounter validation studies;
33. Incident, accident, and death reporting;

34. Information regarding Contractor offered education or training, workforce development requirements and information; and
35. Specific policies and procedures for LTSS such as specific provider responsibilities (EVV/service gap reporting) or level of care assessment and reassessment processes or intake processes.

The Contractor shall offer Provider Policies and Procedures Manual training to all network providers when they are initially enrolled in the network, whenever there are changes in policies or procedures, and upon a provider's request. Updates or changes in operation that require revisions to the Provider Policies and Procedures Manual shall be submitted to FSSA for review and approval in accordance with the requirements outlined in Section 6.11.1.

6.11.3 Provider Dispute Resolution

The Contractor must have written Provider Claims Dispute Resolution policies and procedures for responding to claims disputes for both in-network and out-of-network providers, in accordance with the rules for the claims dispute resolution process for non-contracted providers outlined in Indiana law, 405 IAC 1-1.6. Failure to comply with any of these provisions may result in the imposition of sanctions.

The Contractor's Provider Dispute Resolution process shall comply with the following provisions including but not limited to:

- The Provider Claims Dispute Policy must accept and use the Reporting Manual definitions of Informal and Formal Disputes and address provider claims disputes at the lowest level and a formal process for provider appeals.
- The Provider Claims Dispute Policy must specify the timelines and process for submission of the Informal and Formal Disputes challenging claim payments, denials or recoupments of a timely claim submission. The Contractor shall allow this timeline for submission of a claim dispute to be waived in the event of a retroactive eligibility posting affecting the processing of the original submitted claim or for other events affecting the dispute submission that are out of the provider's control.
- Specific qualified individuals shall be appointed with authority to require corrective action and with requisite experience to administer the claims dispute process.
- The Contractor shall develop and maintain a tracking log for all claims disputes containing sufficient information to identify the provider's name, date of objection, nature of the objection, disposition of the claim dispute, and the date of resolution.
- The Contractor shall submit quarterly reports regarding the number and type of provider objections and appeals as described in the Reporting Manual.
- Claims disputes shall be thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that relevant facts are obtained from all parties.
- All documentation received by the Contractor during the claim dispute process shall be dated upon receipt.
- All claim disputes are filed in a secure designated area and are retained for the appropriate time period following the Contractor's decision or close of the claims dispute, whichever is later, as required by federal or state law.
- The decision for both an informal and formal claims dispute (appeal) must include and describe in detail the following:
    - The nature of the claim dispute.
    - The specific factual and legal basis for the dispute, including but not limited to, an explanation of the specific facts that pertain to the claim dispute, the identification of the member's name, pertinent dates of service, dates and specific reasons for the Contractor denial/payment of the claim, and whether or not the provider is a contracted provider.

    - An explanation of 1) how the Contractor applies the relevant and specific facts in the case to the relevant laws to support the Contractor's decision and 2) the applicable statutes, rules, contractual provisions, policies, and clinical basis. Reference to general legal authorities alone is not acceptable.
    - The provider's right and the timeline to request an appeal (formal dispute) of the initial dispute (informal dispute) resolution by filing a written request to the Contractor.
- Formal claim appeals must be reviewed by a Contractor panel and meet the requirements of 405 IAC 1-1.6-3.
- If a claim dispute is overturned at any level, in full or in part, the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision, along with any applicable interest, within 30 business days of the date of the Decision.
- If the Contractor upholds a claim dispute and a request for binding arbitration or other next level review of the decision is subsequently filed, the Contractor must review the matter to determine why the request for hearing was filed and resolve the matter or the cause of the matter when appropriate.
- If the Contractor reverses a decision to deny, limit or delay services not furnished during the claim dispute or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives the notice reversing the determination [42 CFR 438.424]. Services must be authorized within the above timeframe irrespective of whether the Contractor contests the decision.
- In compliance with Indiana law, IAC 1-1.6-4, binding arbitration must be conducted in accordance with the rules and regulations of the American Health Lawyers Association, pursuant to the Uniform Arbitration Act as adopted in the state of Indiana at Indiana Code 34-57-2-1 et. seq., unless the provider and the Contractor mutually agree to an alternative binding resolution process.
- Timely processes for reporting Provider dispute data and decisions to the Contractor Administration, Quality Management, Provider Relations and other affected Contractor staff for consideration and resolution of claims processing or dispute process issues.

6.11.4 LTSS Provider Engagement

The Contractor shall maintain active communication and collaboration with all providers, including LTSS providers. The Contractor shall solicit and act on feedback from providers to continuously improve provider experience. The Contractor will participate in a state facilitated LTSS provider forum as directed by the State. The frequency of the forum will be determined by the State. The Contractor shall develop and submit a LTSS provider engagement plan to the State for review and approval during Readiness Review and annually, to include but not limited to communication methods implemented to partner with providers, webinars, emails, phone calls, in-person meetings, attendance of association meetings. The engagement plan shall also include identified trends in provider questions and concerns and action steps the MCE implemented to improve trends.

6.12 Contractor Communications with Providers

The Contractor shall have in place policies and procedures to maintain frequent communications and provide information to its provider network. As required by 42 CFR 438.207(c), which sets notification requirements, the Contractor shall notify OMPP of material changes, as described in Section 2.12, that may affect provider procedures at least thirty (30) calendar days prior to notifying its provider network of the changes. The Contractor shall give providers at least forty-five (45) calendar days advance notice of material changes that may affect the providers' procedures such as changes in subcontractors, claims submission procedures or prior authorization policies. The Contractor shall post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

The Contractor shall notify providers of planned and unexpected systems outages which affect provider's ability to submit claims or communicate with the Contractor's provider services helpline. Notification of the systems outage shall be placed on the Contractor's provider website within two hours of identification.

All public facing communications from the Contractor's subcontractors must be approved by FSSA and meet the same timeframe as the Contractor's requirement.

Because some pharmacy services are covered by Indiana Medicaid FFS under the pharmacy benefit consolidation, Contractors must educate providers about which pharmacy services should be submitted to the State fiscal agent for reimbursement, and which should be submitted to the Contractor.

In accordance with 42 CFR 438.102, which relates to provider-enrollee communications, the Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member. Contractor shall communicate this clearly to all providers.

6.12.1 Provider Website

The Contractor shall develop and maintain a website in an FSSA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines for network and out-of-network providers. The website shall be live and meet the requirements of this section on the effective date of the Contract. OMPP shall pre-approve the Contractor's website information and graphic presentations. The Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website described in Section 5.7.3.

To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor shall date each web page, change the date with each revision and allow users print access to the information. The provider website may have secured information available to network providers but shall, at a minimum, have the following information available to all providers:

- Contractor's contact information;
- Provider Policy and Procedure Manual and associated forms;
- All of Contractor's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic;
- The Contractor's preferred drug list;
- Claim submission information including, but not limited to the Contractor submission and processing requirements, paper and electronic submission procedures, emergency room auto-pay lists and frequently asked questions;
- Provider claims dispute resolution procedures for contracted and out-of-network providers;
- Prior authorization procedures, including a complete list of services which require prior authorization and a function to search to see if a service requires authorization
- Appeal procedures;
- Entire network provider listings;
- Links to FSSA and OMPP websites for general Medicaid and [MLTSS Program Name] information;
- HIPAA and 42 CFR Part 2 Privacy Policy and Procedures; and
- Network participation request information including all of the information, steps and forms that are required from the provider for a request to join the Contractor's network and be credentialed.

6.12.2 Provider Newsletters

The Contractor shall distribute provider newsletters not fewer than four (4) times per year that provide updates related to provider services, and policies and procedures specific to the [MLTSS Program Name]. The newsletters must be publicly posted on the Contractor's website and able to be subscribed to by providers, associations, the state, and other members of the public. The Contractor shall notify their contracted providers to changes such as to policy, procedures, contact information, and medical necessity criteria via the Contractor's newsletter in compliance with the Material Change provision in Section 2.12.

6.12.3 Provider Services Helpline

The Contractor shall maintain a toll-free telephone helpline for all providers with questions, concerns or complaints. A portion of the provider helpline staff (proportionate to call volume) shall be dedicated and specially trained to assist the needs of LTSS and HCBS providers. With the exception of the holidays listed below, the Contractor shall staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a twelve (12)-hour business day, from 8 a.m. to 8 p.m. Eastern, Monday through Friday. The provider helpline may be closed on the following holidays: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas.

The Contractor may request that additional days, such as the day after Thanksgiving, be authorized for limited staff attendance. This request shall be submitted to FSSA at least thirty (30) calendar days in advance of the date being requested for limited staff attendance and must be approved by FSSA. For all days with a closure, early closing or limited staff attendance, there shall be a process for providers to process emergency prior authorizations as needed. Call center closures, limited staffing or early closures shall not burden a member's access to care.

The Contractor shall maintain a system for tracking and reporting the number and type of provider calls and inquiries. The Contractor must monitor its provider helpline and report its telephone service performance to FSSA each quarter as described in the [MLTSS Program Name] MCE Reporting Manuals.

6.12.4 IHCP Workshops and Seminars

The State fiscal agent sponsors workshops and seminars for all IHCP providers. The Contractor shall participate in the workshops and attend the provider seminars. A Contractor representative shall be available to make formal presentations and respond to questions during the scheduled time(s). The Contractor is also encouraged to set up an information booth with a representative available during the provider seminars.

6.13 Payment for Health Care-Acquired Conditions and Provider-Preventable Conditions

The Contractor shall develop policies and procedures to prohibit the payment of charges for certain hospital acquired conditions and "never events." These policies and procedures shall be approved by FSSA prior to implementation and upon any subsequent change.

In accordance with 42 CFR 434.6(a)(12), 42 CFR 438.3(g) and 42 CFR 447.26, no payment shall be made by the Contractor to a provider for a provider-preventable condition as identified in the State Plan. All payments made by Contractor for "never events" shall be recovered by the Contractor and/or FSSA as prescribed in section 8.4 Program Integrity Overpayment Recovery.

The Contractor's policies on non-payment of certain hospital-acquired conditions must comply with 405 IAC 1-10.5-5 and the IHCP Provider Bulletin regarding Present on Admission Indicator for Hospital Acquired Conditions dated August 25, 2009 (BT200928), as well as any updates or amendments thereto.

In accordance with 42 CFR 447.26(d), the Contractor shall require that as a condition of payment, all providers agree to comply with the reporting requirements in 42 CFR 447.26(d). The Contractor's policy on non-payment of certain never events shall be developed in accordance with current Medicare National Coverage Determinations (NCDs), as well as any Indiana Medicaid FFS rules or other guidance adopted or issued by FSSA at a future date.

6.14 Member Payment Liability

In accordance with 42 CFR 438.106, which relates to liability for payment, the Contractor and its subcontractors shall ensure that members are not held liable for any of the following:

1. Any payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly;
2. Covered services provided to the member for which FSSA does not pay the Contractor;
3. Covered services provided to the member for which FSSA or the Contractor does not pay the provider that furnishes the services under a contractual, referral or other arrangement; and
4. The Contractor's debts or subcontractor's debts, in the event of the entity's insolvency.

The Contractor shall ensure that its providers do not balance bill its members, i.e., charge the member for covered services above the amount paid to the provider by the Contractor. If the Contractor is aware that an out-of-network, non-IHCP provider, such as an out-of-state emergency services provider, is balance billing a member, the Contractor shall instruct the provider to stop billing the member and to enroll in the IHCP in order to receive reimbursement from the Contractor. The Contractor shall also contact the member to help resolve issues related to the billing.

IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered IHCP service. Provider acceptance of payment from the Contractor as payment in full is a condition of participation in the IHCP. An IHCP provider can bill a member only when the following conditions have been met:

a. The service rendered is determined to be non-covered by the IHCP;
b. The member has exceeded the program limitations for a particular service;
c. The member must understand, before receiving the service, that the service is not covered under the IHCP, and that the member is responsible for the charges associated with the service; and
d. The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service. See the IHCP Provider Manual for more information.

In cases where prior authorization is denied, a provider can bill a member for covered services if certain safeguards are in place and followed by the provider. The Contractor shall establish, communicate and monitor compliance with these procedures, which shall include at least the following: recommend incorporating time frames for MCEs to deny authorizations, for appeals, etc.

a. The provider must establish that authorization has been requested and denied prior to rendering the service;

b. The provider has an opportunity to request review of the authorization decision by the Contractor. The Contractor must inform providers of the contact person, the means for contact, the information required to complete the review and the procedures for expedited review if necessary;

c. If the Contractor maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that authorization has been denied—if the provider is an out-of-network provider, the provider must also explain that covered services may be available without cost in-network if authorization is provided;

d. The member must be informed of the right to contact the Contractor to file an appeal if the member disagrees with the decision to deny authorization;

e. The provider must inform the member of member responsibility for payment if the member chooses to or insists on receiving the services without authorization;

f. The provider must have the right to appeal any denial of payment by the Contractor for denial of authorization.

g. If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver shall meet the following requirements:

    - The waiver is signed only after the member receives the appropriate notification.

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

    - Providers must not use non-specific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.

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

[MLTSS Program Name] will not include copayment requirements from any member for Medicaid-covered services. Some members will be responsible for paying out-of-pocket costs imposed by the Medicare program or other Medicaid waiver liability.

6.15 Provider Directory

The Contractor shall develop a provider directory consistent with the requirements of 42 CFR 438.10(h) and this Contract. The Contractor shall develop and maintain a searchable electronic provider directory and a paper provider directory. The electronic directory on the Contractor's website must be searchable by county and updated at least every two (2) weeks. The paper directory must be updated at least monthly if the Contractor does not have a mobile-enabled, electronic directory; or quarterly if the Contractor has a mobile-enabled electronic directory. Copies of the provider directory in the format requested by the individual shall be available upon request to:

- Members,
- Members' Informal Caregivers,
- FSSA staff,
- Care planning and care coordination staff, and
- Interdisciplinary care team members.

The Contractor may use the same provider directory for its Indiana Medicaid programs as long as the directory clearly designates which population(s) the provider serves. The provider directory shall include providers that are under contract with the MCE including physicians, hospitals, pharmacies, behavioral health providers, specialists, specialty providers such as Community Mental Health Clinics, and LTSS providers. The provider directory shall include the following information for providers under contract with the MCE:

- Provider name as well as any group affiliation (individual practitioner, clinic or agency as appropriate) including primary care physicians, specialists and hospitals;
- Provider's practice setting street address(es), telephone number(s), website URL, (as appropriate), and for LTSS service providers, the service area;
- Services furnished by the provider;

- Provider specialty (as appropriate);
- The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract;
- Whether the provider is accepting new members. If a preferred provider is not accepting new members, the MCE shall assist the member in obtaining an alternate provider;
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and
- Accessibility of the provider's premises (if the member will be receiving services at the provider's premises), including offices, exam rooms and equipment according to state and federal standards.

The Contractor shall include the aforementioned provider network information in an OMPP-approved format (compliant with Section 508 of the US Rehabilitation Act) on its member website. The Contractor Network provider information shall be available to print from a remote user location.

7.0 Quality Improvement

FSSA has established the following Program Quality Goals, which shall remain in effect for the duration of this Contract:

[MLTSS Program Name] Quality Goals:

(1) Develop service plans and deliver services in a manner that is person-centered, member-driven, holistic, involves caregivers, and addresses SDOH.

(2) Ensure continuity of care and seamless experiences for members as they transition into the [MLTSS Program Name] or among providers, settings, or coverage types.

(3) Assure timely access to appropriate services and supports to enable members to live in their setting of choice and promote their well-being and quality of life.

The State-defined measurable objectives, associated performance measures, and performance targets for each goal are listed in Exhibit 2. The State may change these objectives and measures annually, with at least sixty (60) days' notice to Contractor.

For purposes of this Section 7, the following definitions apply. A "quality improvement project" or "QIP" shall mean a plan to remediate an identified program deficiency in response to a sanction or action by FSSA. A "performance improvement project" or "PIP" is a planned strategy for program improvement and is incorporated into Contractor's Quality Management and Improvement Program Work Plan.

7.1 Quality Management and Improvement Program

In accordance with NCQA and CMS standards, as well as the State-defined elements listed below, Contractor shall develop and implement an ongoing Quality Management and Improvement Program (QMIP) for all services it provides to its members. The program shall be comprehensive in range and scope, and it shall cover all demographic groups, care settings and types of services. The program must be uniquely designed to serve Contractor's [MLTSS Program Name] members and must not be combined with quality programs for other Indiana Medicaid programs, other states, or other lines of business.

Through its QMIP, Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services and long-term services and supports to members.

The Contractor's QMIP shall address and support the [MLTSS Program Name] Program Quality Goals as a core component. The QMIP must also support quality improvement more broadly. To that end, the Contractor must perform the activities listed below and must address each of these elements in its annual QMIP and Work Plan:

1. Measure and report to the State on its performance, using standard measures required by the State or CMS, to determine the quality and appropriateness of care and services furnished to all enrollees;

2. Complete [up to 3] State-specified quality improvement projects (QIPs) each year, including any QIPs defined by CMS, in the manner and timeframes specified by the State and in accordance with CMS requirements set forth at 42 CFR 438.330(d)(1);

3. Implement up to three (3) State-defined initiatives or interventions annually, in collaboration with other contractors and in addition to those interventions implemented under QIPs', in support of the [MLTSS Program Name] Quality Program Goals;

4. Design and implement at least one specific and measurable initiative, approved by the State, to support each of the State-defined [MLTSS Program Name] Quality Program Goal objectives for that year as well as establish ongoing program activities that support each objective;

5. Include at least one initiative, consistent with the requirements in Section 6.1, each year to address equity

6. Actively participate in and contribute to program-wide quality improvement activities including FSSA's established quality improvement committees and to the design of quality improvement initiatives and interventions, in collaboration with other contractors and the State;

7. Use the results of quality management and improvement program activities to design improvement activities to support the quality of all Covered Benefits under the program, including long-term services and supports as well as other benefits, with appropriate input from members, informal caregivers and providers including but not limited to survey data, call center data, complaint and grievance data, and input from the Member and Informal Caregiver Advisory Committee; and

8. Produce quality of care reports in the format and at the frequencies specified in Section 10 and the MCE Reporting Manual.

The [MLTSS Program Name] MCE Reporting Manuals contain additional specifications regarding the annual QMIP Work Plan and Quality Improvement Plans, which may be amended from time to time by the State. Contractor shall provide quality program progress reports to the State on no less than a quarterly basis. The Contractor must be prepared to periodically report on its quality management activities to the State's Quality Strategy Committee.

7.1.1 Scope and Standards

Contractor shall meet the requirements of 42 CFR 438 subpart E on Quality Assessment and Performance Improvement and the health plan accreditation requirements of the National Committee for Quality Assurance (NCQA), as well as the requirements listed below (7.1.2 Quality Management and Improvement Program Requirements), in developing its QMIP and the QMIP Work Plan.

7.1.2 Quality Management and Improvement Program Requirements

Contractor shall establish an ongoing and comprehensive QMIP designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and nonclinical care, which is expected to have favorable effect on health outcomes and member and informal caregiver experience and satisfaction.

Contractor shall have a written document to describe its QMIP that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. The program description, work plan and program evaluation shall be exclusive to [MLTSS Program Name] and shall not contain documentation from other state Medicaid programs or product lines operated by Contractor. The Contractor shall make summary information about its program publicly available (on its website and upon request) to providers, members, and informal caregivers. The program summary must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate, and must be approved by FSSA before posting online.

7.1.2.1 Submission and Approval of Program Documents

The QMIP document shall be submitted to FSSA for approval during the readiness review process and then annually in advance of each contract year thereafter, per the due dates established by the State. The plan must be approved by the State before implementation each year.

7.1.2.2 Required Plan Elements

The QMIP shall include, at minimum, all minimum standards as defined in 42 CFR 438.220(b), and as follows:

- An annual and prospective work plan that sets measurable goals, establishes specific objectives, identifies the strategies and activities to be undertaken, monitors results and assesses progress toward the goals;

- Mechanisms to include member voice, needs, and wants in the development of the annual workplan, including:

    - Developing and maintaining mechanisms, including but not limited to Contractor's Member and Informal Caregiver Advisory Committee, to solicit feedback and recommendations from key stakeholders, members, and family members to monitor service quality and to develop strategies to improve member outcomes and quality improvement activities related to the quality of care and system performance.

    - Procedures to conduct member and informal caregiver surveys as required in the Scope of Work and report these survey results to FSSA annually.

    - Procedures to develop and implement targeted strategies to improve health, functional, or quality of life outcomes. Procedures shall include mechanisms for correcting deficiencies.

    - Track and trend member, informal caregiver, and provider issues (e.g., call reasons, complaints, grievances, and appeals, claims disputes).

- Other ways Contractor will assess member experience and satisfaction, as applicable.

- Mechanisms to evaluate quality of care and utilization of services and supports including:
  - Detecting, at least on a quarterly basis, both underutilization and overutilization of services and supports, including service gaps for members receiving HCBS.
  - Assessing quality and appropriateness of care, including both physical and behavioral health as well as long-term services and supports for all members, with a special focus:
    - For members using long-term services and supports, including assessment of quality across care settings and a comparison of services and supports received with those set forth in the member's service plan
    - Participation in state efforts to prevent, detect, and remediate critical incidents for members receiving HCBS.

- Mechanisms to understand and assess members' social determinants of health (SDOH) and to promote connections with social services providers to address member and informal caregiver SDOH needs.

- An approach to monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members in the [MLTSS Program Name] program by all providers in all types of settings, in accordance with the provisions set forth in this Scope of Work, including but not limited to:
  - The identification of key measures of performance, discovery and data collection processes, identification and remediation of issues, and systems improvement activities.
  - Establishment of Processes to measure, evaluate and improve network quality including but not limited to credentialing and recredentialing; provider performance; variation in practice patterns and identification of outliers,
  - Mechanisms to take appropriate action to address service delivery, provider, and other quality management and improvement issues as they are identified, including but not limited to PIPs and QIPs as specified by the State and CMS.
  - Meeting the desired performance levels established by CMS upon release of the national performance measures, in accordance with 42 CFR 438.330(a), which allows CMS to specify measures and topics for performance improvement projects.
  - Analysis of the effectiveness of implemented interventions, to include targeted interventions, to address the unique needs of populations and subpopulations served, including a focus on equity across subpopulations.

- Data collection and monitoring efforts must, at a minimum:
    - Incorporate clinical studies and use of Healthcare Effectiveness Data and Information Set ® (HEDIS®) rate data, survey results, service plans, claims data, and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.
    - Collect and analyze data on race, ethnicity, and language (REL), at a minimum as required by NCQA and State reporting requirements. As part of the program description, Contractor shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected.
    - Collect measurement indicator data related to State-specified areas of clinical priority and quality of care, which FSSA will establish Include procedures to report national performance measures developed by CMS, as well as other state-required performance measures, including member-specific data, as required by the State.
    - Incorporate to the extent possible all relevant data required in the State Medicaid Agency Contract (SMAC) for Contractor's aligned Dually-eligible Special Needs Plan (D-SNP) that would inform any and all state-defined goals and priorities outlined herein. This would include all CAHPS and HEDIS data collected as well as any additional quality data required by the State.
    - Include procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector. The CMS website contains an example of available protocols.
    - Procedures to contract for an NCQA-accredited HEDIS audit as set forth in this scope of work.
    - A plan and procedures to provide training and technical assistance to participating providers, in accordance with this Scope of Work.
- Mechanisms to align provider and member incentives with [MLTSS Program Name] Quality Goals, as well as (if desired) other Contractor-defined goals as applicable:
    - Strategies designed to promote practice patterns, which shall be consistent with evidence-based practice guidelines through the use of education, technical assistance and financial incentives, and the plan should outline how the MCE will share any pay for outcomes (P4O) dollars with providers;
    - Procedures for a provider Value Based Payment program as required under this Scope of Work; and
    - Procedures for provider and member incentive programs, as described in Sections 7.6 and 7.7 of this Scope of Work.

- Other structural components and identification of resources including, at a minimum:
    - The Contractor's guiding philosophy for quality management, including any nationally recognized, standardized approach that is used (e.g., PDCA, Rapid Cycle Improvement, FOCUS-PDCA, Six Sigma);
    - Written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task;
    - Devoted resources including staffing, data sources and analytical resources;
    - The mechanism within Contractor's organization for the governing body to provide strategic direction for the QI program, and for the QI program committee to communicate with the governing body;
    - Specific training about quality that shall be provided by Contractor to staff serving in the QI program committee. Quality Management and Improvement Committee structure, including development of subcommittees and task forces, and the committee's role in monitoring and evaluation of quality and appropriateness of care provided to enrollees;
    - Member and Informal Caregiver Advisory Committee structure, approach to assuring the Committee membership is representative of Contractor's [MLTSS Program Name] membership, and the committee's role in reviewing and advising on quality and appropriateness of care, as well as Contractor's approach to initiatives and interventions to improve quality; and
    - As determined by FSSA, additional standards or revisions to established standards and their respective elements that the State determines are necessary to ensure compliance with changes to federal or state statutes, rules, and regulations as well as to clarify and to address identified needs for improvement.

7.1.3 Annual Quality Management and Improvement Program Work Plan Requirements

The Contractor's Quality Management and Improvement Committee, in collaboration with Contractor's Medical Director, Pharmacy Director, and LTSS Program Manager shall develop an annual QMIP Work Plan. The plan shall identify Contractor's quality management goals and objectives (which should be consistent with [MLTSS Program Name] Quality Goals outlined in Section 7.0 and include a timeline of activities and assessments of progress towards meeting those goals. The plan shall be specifically targeted for [MLTSS Program Name] and shall not cover other states or lines of business and shall include prospective activities over a four (4) year period. The plan shall meet NCQA HEDIS standards for reporting and measuring outcomes, and shall:

- Describe specific activities to support [MLTSS Program Name] Quality Goals

- Include participation, as directed by FSSA, in collaborative efforts with FSSA and other [MLTSS Program Name] MCEs

- Include objectives that are measurable, realistic, and supported by consensus among Contractor's medical and quality improvement staff. The Contractor shall include program activities to improve disparities identified through data collection and make performance data available to providers, members, and informal caregivers.

- FSSA reserves the right to add a requirement for a coordinated or combined quality work plan with Contractor's D-SNP and Medicare Advantage plans.

The Contractor shall submit its QMIP Work Plan to the State during the readiness review. Annually thereafter and at least forty-five (45) days prior to each Contract Year, the Contractor shall provide the State an annual written work plan that details the Contractor's proposed quality assurance and performance improvement projects for the year. The State retains the right of advance written approval and to review on an ongoing basis all aspects of the QMIP, including subsequent changes.

The Contractor shall prepare the annual QMIP Work Plan using standardized reporting templates provided by FSSA.

7.1.4 Staff and Delegation of Quality Program Activities

7.1.4.1 Quality Staffing
The Contractor shall maintain sufficient and qualified staff to manage quality program activities. The Contractor shall establish minimum employment standards and requirements for employees who will be responsible for quality improvement (e.g., education, training, and experience). The Contractor's Medical Director shall be responsible for the coordination and implementation of the QMIP. The Contractor shall include at least one (1) designated professional with expertise in the assessment and delivery of LTSS who will be substantially involved in the quality program.

7.1.4.2 Delegation
As permitted by NCQA and contingent upon prior approval from FSSA, Contractor may be permitted to delegate certain program activities and functions. For information on delegation see Section 2.9 Subcontracts. However, Contractor shall remain responsible for the QMIP, even if portions are delegated to other entities. An entity performing a delegated function is considered a Subcontractor.

In addition to meeting requirements for State approval of a proposed Subcontractor, any delegation of function requires documentation to be submitted for:

- A written delegation agreement between the delegated organization and Contractor, describing the responsibilities of the delegation and Contractor; and
- Policies and procedures detailing Contractor's process for evaluating and monitoring the delegated organization's performance, including corrective actions if delegated services are not performed as agreed upon.

7.1.5 Quality Management and Improvement Committees

Contractor shall form and operate a regular committee structure to oversee its quality programs and shall participate in FSSA committees to support quality efforts program-wide, as follows.

7.1.5.1 Quality Management and Improvement Committee

The Contractor shall establish an [MLTSS Program Name] Quality Management and Improvement Committee to develop, approve, implement, monitor, and evaluate the QMIP and Work Plan. This committee may not be combined with the quality committee(s) for any other Indiana Medicaid programs operated by Contractor, or for other states or lines of business. The committee shall recommend policy decisions, ensure providers are involved in the quality management and improvement program, institute needed action, and ensure that appropriate follow-up occurs. The Contractor's Medical Director, LTSS Program Manager, and Pharmacy Director shall be active members in Contractor's [MLTSS Program Name] Quality Management and Improvement Committee. The committee shall be representative of management staff, including provider relations, LTSS support staff, and other department heads, as well as include stakeholders such as members, aging and disability-led advocacy groups, medical and behavioral health providers, LTSS providers, community partners, advocates, caregivers, and subcontractors, as appropriate. Subcontractors providing delegated direct services to members shall be represented on the committee.

The Contractor shall have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, Contractor's [MLTSS Program Name] Quality Management and Improvement Committee and QMIP Work Plan. All functional units in Contractor's organizational structure shall integrate their performance measures, operational activities and outcome assessments with Contractor's internal quality management and improvement committee to support Contractor's quality management and improvement goals and objectives.

Contractor shall submit minutes of these meetings to FSSA within seven (7) calendar days following each meeting.

7.1.5.2 Indiana Aging and LTSS Advisory Committee

FSSA will form and convene a quarterly independent Aging and LTSS Advisory Committee before the end of the first year of the program. This committee will include a cross-representation of members, caregivers (formal and informal), member advocates, aging and disability-led advocacy groups, subject matter experts, and other independent stakeholders. This committee will provide recommendations and proposals for the development of quality measures, reporting requirements, transparency and data requirements, and value-based reimbursement methodologies to State staff. Additionally, the committee will be a venue to discuss concerns relating to service by providers and the Managed Care Entities to meet member needs. As appropriate, the Aging and LTSS Advisory Committee should consult with the External Quality Review Organization contractor in order to align quality goals and measures. The Contractor will not have voting membership on the committee but must send designees to all committees to support the work.

7.1.6 Annual Quality Management and Improvement Program Evaluation and Update

The Contractor must conduct an annual evaluation of its QMIP consistent with state and federal regulations. This evaluation must review the impact and effectiveness of Contractor's QMIP including performance on standard measures and Contractor's performance improvement projects. The Contractor must identify quality improvement activities that resulted in measurable, meaningful, and sustained improved health care outcomes for the [MLTSS Program Name] population. The Contractor will describe the quality strategies, including quantitative evidence of improvements, lessons learned, and how the quality improvement outcomes will influence future activities. To the extent provider and/or member incentives are utilized as a strategy to impact a quality goal, the evaluation should reflect the impact of the incentive toward achieving the goal. The Contractor must submit the written evaluation to the State by January 31st of the Contract Year.

The Contractor must make a summary of its QMIP evaluation available on a public web page associated with Contractor. The Contractor must prominently feature the description of major workplan initiatives including at least one quality improvement activity each year that addresses equity. The web page must be updated annually by February 28th of the Contract Year. The State holds the right to publish the website link on the State's public website and public comments will be accepted. The Contractor will be held responsible to respond to public comments within thirty (30) days.

7.1.7 Annual Quality Management and Improvement Program Workgroup

The Contractor shall participate in FSSA's annual Quality Management and Performance Improvement Program. The State, in collaboration with Contractor and other stakeholders, will use the FSSA Quality Management and Performance Improvement Program to determine and prioritize activities and initiatives based on areas of importance to the State and CMS. As part of FSSA's annual performance improvement program, the State will establish a Quality Strategy Committee.

The Contractor shall have its Quality Management Manager and other appropriate personnel, including those with LTSS expertise, attend and participate in the State's regularly scheduled Quality Strategy Committee meetings. The Contractor is encouraged to recommend additional attendees and other stakeholders to Quality Strategy Committee meetings. Additionally, the Medical Director and the Pharmacy Director shall attend and participate in the State's Quality Strategy Committee meetings at least quarterly, to update the State and report on Contractor's quality management and improvement activities and outcomes.

Contractor shall agree to establish and implement policies and procedures that are agreed to and/or described by [MLTSS Program Name] in order to address specific quality concerns.

7.1.8 Information System & Data Collection to Support Quality

7.1.8.1 Quality Information Systems

Contractor must operate an information system that supports initial and ongoing operations and quality management and improvement program. Contractor must maintain a health information system that collects, analyzes, integrates, and reports data. The information system must achieve the following objectives, at minimum:

- Collect data on enrollee, member, caregiver, and provider characteristics, and on services furnished;
- Ensure that data received from Providers is accurate and complete by:
    1. Verifying the accuracy and timeliness of reported data;

2. Screening or editing the data for completeness, logic, and consistency; and
3. Collecting service information in standardized formats to the extent feasible and appropriate; and
4. Make all collected data available to the State and CMS upon request. The Contractor must provide any and all requested source data and/or methodologies used in their reporting of quality information and data submissions to FSSA and CMS in an agreed upon format. Furthermore, the Contractor must maintain sufficient staff capacity to sufficiently answer any FSSA inquiries regarding data collection and metric calculation including but not limited to data and information related to financials, clinical outcomes, quality, operations, hearing and appeals, and provider/patient complaints.

7.1.8.2 Quality Reporting
The Contractor shall, at minimum,

1. Measure and report to the State on its performance, using standard measures required by the State or as required by Centers for Medicare & Medicaid Services;
2. Submit specified data to the State that enables the State to measure Contractor's performance using standardized measures, as specified by the State; or
3. Perform a combination of the above activities.

In compliance with state and federal regulations, Contractor shall submit quality improvement data, including data that meets HEDIS standards for reporting and measuring outcomes, to the State that includes the status and results of performance improvement projects and allows reliable comparison of performance of managed health care plans. Additionally, Contractor must submit information requested by the State to complete the State's annual Quality Strategy Plan for CMS.

The Contractor must submit annually the Relative Resource Use (RRU) data to the State within ten (10) business days of receipt from NCQA. The Contractor must submit both the Regional and National RRU results.

The following information shall be made available by the Contractor upon request:

- The annual QMIP workplan and its approval by the Contractor's governing board or its designee;
- Results of the annual evaluation of the quality management program;
- Evidence of efforts undertaken by the Contractor to:
    1. Monitor the quality of assessments and member-centered care plans;
    2. Monitor the completeness and accuracy of completed functional screens;
    3. Monitor the member's long-term care and personal experience outcomes to ensure the setting in which the member resides supports integration into the greater community, including

opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community;

4. Monitor access to providers and verify that authorized services were actually provided;
5. Detect, identify and remediate Unusual Occurrences consistent with [MLTSS Program Name] requirements; and
6. Monitor the quality of any subcontractors.
7. Appeals and grievances that were resolved as requested by the members.

7.1.9 External Quality Review

Pursuant to federal regulation, the State shall arrange for an annual, external independent review of each Contractor's quality of, timeliness of and access to health care services. The Contractor shall provide all information required for this review in the timeframe and format requested by the external quality review organization. The Contractor shall cooperate with and participate in all external quality review activities. The Contractor's QMIP shall incorporate and address findings through a corrective action plan and development process from these external quality reviews.

7.1.10 Cooperation with the State

The FSSA shall conduct ongoing monitoring of the Contractor, as required by 42 CFR 438.66(a) and (b), to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of the FSSA and may include, but is not limited to, both scheduled and unannounced onsite visits, review of policies and procedures and performance reporting.

These monitoring procedures will include, but are not limited to, operations related to the following [42 CFR 438.66(c)(1) – (12)]:

1. Member enrollment and disenrollment,
2. Processing member grievances and appeals,
3. Processing Provider Claim Disputes and Appeals,
4. Findings from the State's External Quality Review process,
5. Results of member satisfaction surveys conducted by the Contractor,
6. Performance on required quality measures,
7. Medical management committee reports and minutes,
8. Annual quality improvement plan,
9. Audited financial and encounter data,
10. Medical loss ratio summary reports,
11. Customer service performance data, and
12. Any other data related to the provision of LTSS including the Contractor's DSNP

Reporting requirements are detailed further in Section 10.0 and the State MCE Reporting Manual.

The reviews will identify and make recommendations for areas of improvement, monitor the Contractor's progress towards implementing mandated programs or operational enhancements, and provide the Contractor with technical assistance when necessary. In preparation for planned

onsite reviews, the Contractor shall cooperate with FSSA by forwarding in advance policies, procedures, job descriptions, contracts, records, logs, and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities.

The Contractor shall not distribute or otherwise make available any FSSA Operational Review Tool, draft or final Operational Report to other program Contractors.

For additional requirements, refer to Section 10.0 Performance Reporting and Incentives, Exhibit 4, Section 9.1 FSSA's Right to Audit and Monitor, and Exhibit 2 regarding Contract Compliance.

7.1.11 Publication of Quality Performance Reports

The State reserves the right to publish Contractor-level and provider-level quality performance data and information, including but not limited to: Contractor performance related to [MLTSS Program Name] Quality Program Goals, the status and impact of quality improvement initiatives and interventions, and information regarding the status of Contractor QIPs and Corrective Action Plans (CAPs).

7.1.12 HEDIS Audit

The Contractor must engage a certified HEDIS auditor to conduct a separate HEDIS audit for Contractor's [MLTSS Program Name] lines of business. The HEDIS audit and report must be based upon the NCQA methodology for sampling of HEDIS data. The contractor must report audited HEDIS rates to the State**.**

7.1.13 Waiver Assurances

The State must meet Federal requirements for the 1915(c) waiver(s) that provide the Department with authority to implement the [MLTSS Program Name]. The Contractor shall fully comply and implement to the State's satisfaction any delegated activities by the State for any Federal waiver requirements. These include the HCBS waiver assurances found at 42 CFR 441.302. The Contractor will also have additional requirements related to HCBS waiver assurances including:

1. Service plan in accordance with 42 CFR 441.301(b)(1)(I);
2. Inpatients in accordance with 42 CFR 441.301(b)(1)(ii);
3. Room and Board in accordance with 42 CFR 441.310(a(2);
4. Access to Services;
5. Free Choice of Provider in accordance with 42 CFR 431.151 as amended by the 1915(b) waiver for [MLTSS Program Name];
6. FFP Limitation in accordance with 42 CFR 433 Subpart D;
7. Fair Hearing in accordance with 42 CFR 432 Subpart E;
8. Quality Improvement including all performance measures related to these assurances;
9. Limited English Proficient Persons.

The Contractor shall report on the Waiver assurance measures according to the requirements and timelines described in the Policy and Procedures Manual.

7.1.14 Incident Reporting and Management

Incidents are defined as unusual occurrences affecting the health and safety of a [MLTSS Program Name] enrollee receiving HCBS and include the following:

1. Alleged, suspected, reported or observed abuse/battery, neglect, or exploitation of a member
2. The unexpected death of a member
3. Significant injuries to the member requiring emergent medical intervention
4. Any threat or attempt of suicide made by the member
5. Any unusual hospitalization due to a significant change in health and/or mental status may require a change in service provision
6. Member elopement or missing person
7. Inadequate formal or informal support for a member, including inadequate supervision, which endangers the member
8. Medication error occurring
9. A residence that compromises the health and safety of a member
10. Suspected or observed criminal activity by:
    a. provider's staff when it affects or has the potential to affect the member's care;
    b. a family member of a member receiving services when it affects or has the potential to affect the member's care or services; or
    c. the member receiving services;
11. Police arrest of the member or any person responsible for the care of the member
12. A major disturbance or threat to public safety created by the member
13. Any use of restraints.

All providers of HCBS services, including Service Coordinators, are required to submit incident reports to FSSA when any of the events in Section 7.1.12 are identified.

Incident reports shall be submitted through the FSSA web-based Incident Reporting System. If web access is unavailable, incidents can be reported to FSSA by telephone, and e-mail.

HCBS providers are required to submit an incident report for any reportable incident within forty-eight (48) hours of the time of the incident or becoming aware of the incident. However, if an initial report involves a member death, or an allegation or suspicion of abuse, neglect or exploitation, the report must be submitted within twenty-four (24) hours of "first knowledge" of the incident.

Indiana law requires reporting of known or suspected abuse, neglect, or exploitation of an adult to Adult Protective Services. A twenty-four (24) hour hot-line connected to the statewide Adult Protective Services (APS) system is available for this reporting, or reports can be made to the local APS or County Prosecutor's office.

The Contractor shall track incidents and shall review and analyze critical incidents to identify and address as potential and actual quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from Adult Protective Service APS if available); identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of [MLTSS Program Name] HCBS. The Contractors

shall provide analyses, reports and strategies to address critical incidents to FSSA consistent with the requirements of the Policy and Procedure manual.

Additionally, the Contractor shall participate in the State's mortality review committee. Participation may include providing medical information, claims history, care management notes or other documentation to the State.

7.2 Surveys

The Contractor is required to perform and/or assist with the following annual surveys as described below:

- Member Surveys:
  i. Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Health Plan, HCBS and Nursing Home
  ii. National Core Indicators Survey- Aging and Disabilities
- Informal Caregiver Survey
- Provider Surveys

The Contractor shall incorporate and address findings from surveys and other analytic activities to assess the quality of care and services provided to members and identify opportunities for Contractor improvement. The Contractor shall submit a report (3 months after the initial survey period and annually thereafter) to FSSA summarizing the member and informal caregiver survey methods and findings and identifying opportunities for improvement. The Contractor shall participate in the delivery and/or results review of surveys as requested by the State. The State reserves the right to rely upon member survey findings as a basis for P4O and VBP.

The Contractor shall provide survey results to the State (including de-identified member-level data) from all independently administered survey, by stratifications defined by the State. The State will analyze the findings to identify required performance improvement activities and shall make the findings available to stakeholders.

Summary results of Contractor's surveys may become public information and available to all interested parties on the State's public website. The Contractor may be required to participate in workgroups and other efforts that are initiated based on the survey results. The Contractor may participate in or conduct additional surveys based upon findings from the previously conducted surveys, as approved by the State, as part of designing its QMIP For non-required surveys, The Contractor shall provide notification and receive State approval prior to conducting the survey. The notification shall include a project scope statement, project timeline and a copy of the survey instrument.

Survey findings or performance rates for survey questions may result in regulatory action including, but not limited to, Contractor being required to develop a Corrective Action Plan (CAP) to improve areas of concern noted by the State. Failure to effectively develop or implement CAPs and drive improvement may result in non-compliance actions as described in Exhibit 2.

7.2.1 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Contractor shall enter into an agreement with a State-approved vendor that is certified by NCQA to perform annual CAHPS surveys in accordance with AHRQ standards. The Contractor shall use the most current CAHPS version specified by AHRQ as of the time of survey administration and shall administer the survey for a time period specified by FSSA. The survey must be conducted in accordance with AHRQ and NCQA guidelines.

Contractor shall report survey results to the State separately for each MCE-administered survey listed below. Contractor shall submit validated survey results to the State and NCQA by June 15th of each calendar year beginning in 2024 unless otherwise specified by the State. The Contractor must forward CAHPS data to the State electronically in a file and format determined by the State. Contractor must also report the survey data collected from the required annual participation of its aligned D-SNP in the Medicare Advantage and Prescription Drug Plan (MA & PDP) CAHPS survey. Contractor shall report data from this survey as required under Chapter 5, Section 30 of the Medicare Managed Care Manual and consistent with the D-SNP requirements set out in Indiana's State Medicaid Agency Contract (SMAC).

The Contractor must add all state-specific modifications, which may include unique specifications or content as directed by the State. The State requires that Contractor include all HCBS core questions in the survey. The State may require that Contractor include supplemental questions. The State may require the addition of up to six (6) supplemental state-specific questions.

For all CAHPs surveys, the State will, at least one hundred and eighty (180) days prior to the administration of the survey, notify Contractor of the sample size and sampling methodology. The sampling methodology will be designed to oversample to allow for statistically representative measurement of equity by race/ethnicity, rural/urban status, Area Agency on Aging service region, and other factors.

The Contractor shall have its sample validated by an NCQA-certified HEDIS Auditor. The sample size will be determined by the State based on CMS technical assistance, historic response rates, and the size of the target population. To increase response rates in order to meet the target number of completed surveys, the Contractor may oversample, send a pre-notification letter and/or postcard to enrollees to let them know they may be called to participate in the survey, and/or increase the number of call attempts made to enrollees on different days and at different times.

The Contractor shall annually provide to the State the survey result from each independently-administered CAHPs survey, as listed below. The Contractor shall provide survey results statewide stratified by, at minimum, Race, Ethnicity, Language. The Contractor shall also provide survey results by regions defined by the State. The State reserves the right to define additional stratification requirements. Each CAHPS survey must be based upon the NCQA methodology for sampling of CAHPS data. Required CAHPS surveys will include:

- CAHPS Health Plan Survey
- CAHPS Home and Community-Based Services Survey
- CAHPS Nursing Home Survey (all three standardized surveys)

The MCE's independently-administered CAHPS surveys listed above shall be conducted solely for Contractor's [MLTSS Program Name] line of business. The Contractor's vendor must submit Member-level data files to NCQA for calculation of HEDIS CAHPS survey results.

During the first year of the program, the State may direct the Contractor to conduct quarterly pulse surveys as designed by the State and based on a subset of the CAHPS survey tool, in order to facilitate regular rapid cycle feedback and quality improvement for the [MLTSS Program Name] program. Topics such as utilization management performance, wait times for services, and culturally competent treatment may be considered for inclusion. The sample size will be determined by the State based on CMS technical assistance, historic response rates, and the size of the target population. To increase response rates in order to meet the target number of completed surveys, the Contractor may oversample, send a pre-notification letter and/or postcard to enrollees to let them know they may be called to participate in the survey, and/or increase the number of call attempts made to enrollees on different days and at different times.

7.2.2 National Core Indicators Survey- Aging and Disabilities

The State will conduct an annual quality of life survey for members enrolled in [MLTSS Program Name] using the National Core Indicators – Aging and Disabilities consumer survey. To support this effort, Contractor shall collect and report Pre-Survey and Background Information for each member in the sample (including the oversample) in accordance with instructions and timeframes established by the State and otherwise cooperate with and support the State during the survey administration process. The survey may use sampling methodology designed to oversample by race/ethnicity, rural/urban status, MCE, Area Agency on Aging service region, and other factors. The Contractor may be required to review survey results and develop corrective action plans or quality improvement projects.

7.2.3 Caregiver Survey

A statewide caregiver survey may be administered to measure key experience and quality of life indicators using best practices for reaching certain populations. The State reserves the right to administer the survey then provide survey results to each Contractor or to require each [MLTSS Program Name] contractor to administer a caregiver survey using a standardized survey tool provided by the State. The Contractor must respond to data requests, adhere to sampling methodologies, and survey administration protocols, and otherwise cooperate with and support the State during the survey administration process. The State and Contractor shall analyze the findings to identify required performance improvement activities and shall make the findings available to stakeholders.

The timing and approach to administering this survey will be determined by the State. The State will inform Contractor of the survey timing and approach at least ninety (90) days prior to survey administration. The conduct of a caregiver survey specific to enrollees in [MLTSS Program Name] may be considered for future years.

7.2.4 Provider Surveys

The Contractor may be required to administer provider satisfaction surveys. Details will be set forth in the MCE Reporting Manual.

7.2.5 Additional Surveys

The State may require Contractor to conduct additional surveys to measure key experience and quality of life indicators using best practices for reaching certain populations.

The State has the right to require Contractor to conduct additional pulse surveys based on CAHPS in future years.

7.3 Value Based Payment (VBP)

7.3.1 VBP Program Design

The State will use Value Based Payment (VBP) as one tool in Indiana's [MLTSS Program Name] quality framework to leverage the managed care model toward a health care system where members' experience and health outcomes are improved. VBP is defined as linking provider payment to improved performance by health care providers, in order to hold health care providers accountable for both the cost and quality of care they provide, attempt to reduce inappropriate care, and identify and reward the best-performing providers. Informed by national best practices, FSSA will design its VBP program to support progress in achieving the [MLTSS Program Name] Quality Goals. The program will be implemented using a phased approach. Any VBP program

design will be finalized no less than one hundred and eighty (180) days prior to the date on which it will be effective.

The State reserves the right to establish VBP methodologies that Contractor, and all other [MLTSS Program Name] contractors, must implement. The VBP methodologies will be applied to home- and community-based services and nursing facility services, as well as to providers of other covered services. The State also reserves the right to establish targets or minimum levels for Contractor's VBP provider participation rates.

7.3.2 VBP Program Participation

The Contractor shall participate in the state-directed [MLTSS Program Name] VBP Program and shall support the program by contributing input for the design and ongoing development of the program, working together with the State, other [MLTSS Program Name] contractors, the Aging and LTSS Advisory Committee, and other stakeholders.

The Contractor shall reimburse nursing facilities in accordance with the Nursing Facility Quality Payment Program designed by the State. The State reserves the right to amend and redesign the Nursing Facility Quality Payment Program as needed.

The Contractor shall support the State in actively helping to advance providers along the VBP continuum – consistent with the Health Care Payment Learning and Action Network framework - to advance value in the [MLTSS Program Name] program. The Contractor shall also collaborate with the State on any multi-payer VBP activities. The Contractor shall also collaborate with the State to develop, implement, and continue to build upon, VBP arrangements, particularly in, but not limited to, the home- and community-based providers.

The Contractor may establish additional VBP programs to supplement those directed by the State. The Contractor shall develop procedures to routinely assess VBP programs, state-directed or supplemental, for unintended consequences that perpetuate or increase health disparities and make modifications as needed.

7.3.3 VBP Metrics and Reporting

The Contractor shall routinely collect, update, report, and reconcile to the State, data on Contractor's efforts and progress towards achieving the goals of the [MLTSS Program Name] VBP Program. Contractor shall also submit reports for any additional Contractor-defined VBP arrangements, as applicable.

The State may require the health plan to align standard metrics and reporting for providers participating in a VBP agreement with other federal or community programmatic required metrics and reporting to reduce administrative burden for the provider community. The Contractor will provide technical assistance to participating providers to support and increase provider VBP capabilities, including data collection, reporting, and analytics.

7.4 Pay-for-Outcomes Quality Incentive Programs

FSSA shall require Contractors to participate in a pay for outcomes (P4O) program that focuses on rewarding Contractors' efforts to improve quality and outcomes for [MLTSS Program Name] members. The P4O program will at a minimum incentivize objectives that support the Program Quality Goals but may be used to support additional State goals. FSSA shall provide, at minimum, financial performance incentives to Contractors based on performance targets in priority areas established by the State. The Contractor incentives and performance targets will be set forth in Exhibit 2.

The State shall have the right to revise P4O measures on an annual basis. Incentive payment performance may be made available to stakeholders under the same terms of performance, or the public.

In Years Two (2) through Four (4) and possible contract extension years of the State Contract, the State shall also have the right to require Contractor to invest a portion of the P4O payment in infrastructure that supports the [MLTSS Program Name] Quality Goals or to distribute a portion of the P4O payment to its network providers in support of the [MLTSS Program Name] Quality Goals. The State will notify Contractor of such requirements at least one hundred and eighty (180) days before their effective date.

Additional conditions to payment of incentive amounts are provided in Exhibit 2.

In addition to P4O, the State reserves the right to adjust the auto-assignment algorithm or add criteria including but not limited to quality measures or cost or utilization management performance, by means including but not limited to the following:

- Years Two (2) through Four (4) and possible contract extension years: To reflect Contractor's performance on Pay-for-Outcomes measures based on a methodology to be specified by the State no later than ninety (90) days after the Contract effective date. May be adjusted to reflect preference for contractors that are determined to be noncompliant with the prior or current year's quality program workplans and to exclude those that are subject to Corrective Action Plans.

7.5 Provider Feedback Reporting and Technical Assistance

The Contractor must provide training and technical assistance, publish provider feedback reports, and build infrastructure to help all of its network providers prepare for, and engage in, its quality improvement program and in any VBP programs. Training must occur upon provider onboarding as well as at least annually, or as needed to address provider questions or issues.

At a minimum, such training shall inform network providers about the [MLTSS Program Name] Quality Program Goals and the provider's role in contributing to the achievement of these goals.

7.5.1 Technical assistance components

Technical assistance to participating providers must, at a minimum, support the provider in:

- Understanding provider feedback quality and utilization reports and supporting provider capabilities to meet performance improvement targets
- Understand and assess members' social determinants of health (SDOH) and connecting with social services providers to address member and informal caregiver SDOH needs.

7.5.2 Jointly developed technical assistance

Contractor will jointly develop certain types of technical assistance programs, as follows. The Contractor will collaborate with FSSA and other [MLTSS Program Name] contractors to:

- Provide training and technical assistance, and build infrastructure to help network providers prepare for, and engage in, VBP (including how to utilize feedback reports, best practices for practice adoption of VBP engagement strategies and use of Contractor's provider tools, staff training strategies, and effective patient engagement approaches, etc.);
- Establish a core set of measures that will be included in all provider feedback reports, standardized across all [MLTSS Program Name] Contractors issuing the feedback reports;
- Provide targeted training related to particular quality improvement initiatives, including but not limited to establishing an HCBS provider learning network to support network providers, as they prepare for, adopt, and adapt to VBP arrangements;

- Support providers in understanding and assessing SDOH, and connecting with social services providers to address member and informal caregiver SDOH needs; and
- Support providers in addressing Direct Service Professionals workforce development, in coordination with the State, including supporting the State's efforts as conducted under the HCBS Spending Plan

Contractor will be required to submit quarterly reports to FSSA to show total trainings completed, percent of network reached, topics covered, and other report elements as defined by the State as noted in the Reporting Manual.

7.6 Provider Incentive Programs

Contractors may establish a performance-based incentive system for its providers for Contractor's [MLTSS Program Name] providers. The Contractor may determine its own methodology for incentivizing providers. The provider incentive programs shall, at a minimum, include incentives that are aligned with all of the [MLTSS program name] Program Quality Goals. Contractor may offer additional provider incentives targeting additional areas of performance to support the needs of its membership, but such additions should be evidence-based, and the needs documented based on clinical data, provider performance, or other relevant data. The Contractor must obtain FSSA approval at least 30 days prior to implementing any provider incentive program and before making any changes thereto. The State encourages creativity in designing pay for performance programs, consistent with the requirements below. If Contractor offers financial incentives to providers, these payments shall be above and beyond the standard Medicaid fee-for-service fee schedule.

Section 1876(i)(8) of the Social Security Act and federal regulations 42 CFR 438.10(f)(3), 42 CFR 422.208 and 42 CFR 422.210 provide information regarding physician incentive plans. The Contractor shall comply with all federal regulations regarding the physician incentive plan and supply to FSSA information on its plan as required in the regulations and with sufficient detail to permit FSSA to determine whether the incentive plan complies with the federal requirements. The Contractor shall provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.

Physician incentive plans shall comply with the following requirements:

- The Contractor shall make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member; and
- The Contractor shall meet requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.10(f)(3).

For any provider incentives offered, Contractor must collect data and assess the impact of the incentives toward achieving their intended purpose. Results of the impacts achieved must be included in quality workplan updates and program reports to the State. The State reserves the right to prospectively end its approval of a Contractor's provider incentive based on these results.

7.7 Member Incentive Programs

Contractor's member incentive programs must be directly related to improving health outcomes or quality of life. Member incentives may be financial or non-financial. The Contractor must obtain FSSA approval at least 30 days prior to implementing any member incentive program and before making any changes thereto. The State encourages creativity in designing member incentive programs, consistent with the requirements below.

Examples of appropriate Member Incentives could include gift certificates for groceries; phone cards; or gifts such as exercise equipment, first aid kits, or personal care items.

For any member incentives offered, the Contractor must collect data and assess the impact of the incentives toward achieving their intended purpose. Results of the impacts achieved must be included in quality workplan updates and program reports to the State. The State reserves the right to prospectively end its approval of a Contractor's member incentive based on these results.

Except as provided herein, Contractor may not offer gifts or incentives greater than one hundred dollars ($100.00) for each incentive, unless an exception is approved by FSSA. The Contractor may petition FSSA, in the manner prescribed by FSSA, for authorization to offer items or incentives greater than one hundred dollars ($100.00) Such incentives may not be disproportionate to the value of the service provided, as determined by FSSA. Petitions to provide enhanced incentives for preventive care shall be reviewed on a case-by-case basis, and FSSA shall retain full discretion in determining whether the enhanced incentives will be approved. In any member incentive program, the incentives shall be tied directly to improving health outcomes or quality of life. For example, the member incentive programs can encourage annual health screenings and well-visits. Contractors may use incentives to encourage participation in Population Health programs. Contractors should develop member incentives designed to encourage appropriate utilization of health care services and long-term services and supports, increase adherence to keeping medical appointments and encourage the receipt of health care services in the appropriate treatment setting. Additionally, Contractor shall comply with those requirements found in 42 CFR 1003.101:

> "Remuneration… (4) Incentives given to individuals to promote the delivery of preventive care services where the delivery of such services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or an applicable State health care program. Such incentives may include the provision of preventive care, but may not include—
>
> - Cash or instruments convertible to cash; or
> - An incentive the value of which is disproportionally large in relationship to the value of the preventive care service (*i.e.,* either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care) …"

7.7.1 Required Member Incentives

Contractors shall establish, at a minimum, one member incentive program aligned with each of the [MLTSS Program Name] Program Quality Goals.

7.7.2 Optional Member Incentives

Contractor may offer additional member incentives targeting additional areas of performance to support the needs of its membership, but such additions should be evidence-based, and the needs documented based on clinical data, member and informal caregiver needs and wants, or other relevant data. Contractor will determine its own methodology for providing incentives to members. For example, Contractor may offer additional member incentives for:

- Obtaining recommended preventive care (including dental);
- Complying with treatment in a prevention and wellness programs, care management or complex case management program;
- Making healthy lifestyle decisions such as quitting smoking or losing weight; or
- Completing a health screening.

7.8 Utilization Management Program

The Contractor must operate and maintain its own utilization management program. The Contractor shall include utilization management measurements in their Quality Management and Improvement Program Work Plan as set forth in Section 7.1.2.

The Contractor's utilization management program shall not be limited to traditional utilization management activities, such as prior authorization. The Contractor must maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures and systems in place to assist utilization management staff to identify instances of over- and under-utilization of Emergency room services, non-emergency medical transportation services and other health care services, identify aberrant provider practice patterns (especially related to Emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams), ensure active participation of a utilization review committee, evaluate efficiency and appropriateness of service delivery, incorporate subcontractor's performance data, facilitate program management and long-term quality and identify critical quality of care issues.

The Contractor's utilization management program must link members to prevention and wellness programs(s), care management, complex case management and service coordination, as set forth in Section 4.0. This includes, but is not limited to, integrating prior authorization requests for the identification of members with real-time clinical needs. The Contractor's utilization management program must also encourage health literacy and informed, responsible medical decision making. For example, Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting. Contractors shall also be responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

The Contractor shall monitor utilization through retrospective reviews and will identify areas of high and low utilization and identify key reasons for the utilization patterns. The Contractor must identify those members that are high utilizers of Emergency room services and/or other services, including pharmacy, and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate prevention and wellness programs(s), care coordination or complex care management services. The Contractor must also use this data to identify additional prevention and wellness programs that are needed. Any member with Emergency room utilization must be outreached to again offer complex case management or care coordination. The Contractor may use the Right Choices Program (RCP), as described in Section 4.2.4, in identifying members to refer to prevention and wellness programs(s), care coordination or complex case management. The Contractor must identify members with high utilization of controlled substances following the policies and procedures of the Right Choices Program (RCP), as described in Section 4.2.4.

As part of its utilization review, the Contractor shall monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards. The Contractor must develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards.

The Contractor shall not delegate utilization management functions or responsibilities to subcontractors with the exception of pharmacy, vision, and/or dental. Subcontracts are subject to State approval. If the Contractor delegates some of its prior authorization function to subcontractors, the Contractor must conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures and state and federal law.

7.8.1 Utilization Management Staffing and Training

Utilization management staff must receive ongoing training regarding interpretation and application of the utilization management guidelines. The Contractor must be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by FSSA. The State reserves the right to standardize certain parts of the prior authorization reporting process across the Contractors, such as requiring the Contractors to adopt and apply the same definitions regarding pended, denied, suspended claims, etc. When adopted, these standards shall be set forth in the Reporting Manual.

The Contractor shall staff and operate a utilization management helpline at a minimum during business hours. The helpline staff shall be equipped to provide customer service to providers with authorization and coverage questions and authorize post-emergency department stabilization services.

When the Contractor conducts a prudent layperson review to determine whether an emergency medical condition exists, the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field.

Clinical professionals who have appropriate clinical expertise in the treatment of a member's condition or disease must make all decisions to deny a service authorization request (a request for the provision of a service by or on behalf of a member) or to authorize a service in an amount, duration or scope that is less than requested. The Contractor shall have a full time Geriatrician on staff or physician with ten (10) years of clinical practice with older adults with oversight of utilization management to review all denials of prior authorization requests. Only physicians and nurses licensed in Indiana may deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.

The Contractor shall not provide incentives to utilization management staff or to providers for denying, limiting or discontinuing medically necessary services. FSSA may audit Contractor denials, appeals and authorization requests. The Contractor shall adhere to the requirements and timelines for prior authorization as described in Section 3.22 regarding transitions and Continuity of Care. FSSA may waive certain administrative requirements, including prior authorization procedures, to the extent that such waivers are allowed by law and are consistent with policy objectives. The Contractor may be required to comply with such waivers and will be provided with prior notice by FSSA.

7.8.2 Medical Service and Pharmacy Prior Authorization (Non-HCBS services)

The Contractor may place appropriate limits on coverage on the basis of medical necessity, provided the services furnished can reasonably be expected to achieve their purpose. The Contractor is prohibited from arbitrarily denying or reducing the amount, duration or scope of required services solely because of diagnosis, type of illness or condition. The Contractor shall consider the status of the member when determining the amount or duration of services to approve, taking into consideration that individuals in this program are likely to need long-term therapies to maintain their current health and activities. The Contractor shall not use improvement in function as a criteria for approving continuation of services that enable the member to maintain their health status or prevent the member from experiencing a more significant decline.

The Contractor will not refer members to publicly supported health care resources as a means of avoiding costs.

For select IHCP published criteria or practice guidelines, as identified by the State, the Contractor's utilization management program cannot be more restrictive than the fee-for-service criteria and guidelines. The Contractor shall engage with the State to review already published medically necessary prior authorization criteria. The State reserves the right to further standardize

prior authorization criteria, processes, administrative processes, forms/documentation and/or to require the use of a single prior authorization portal across Contractors.

The Contractor must use non-company customized versions of MCG and InterQual or other commercially available criteria when such products are used for utilization management reviews. The Contractor is expected to always use MCG and InterQual for the following utilization management reviews: acute inpatient, skilled nursing facility, acute inpatient rehabilitation, long-term acute care facility and behavioral health inpatient.

For areas not addressed by IHCP criteria and MCG/InterQual, the Contractor may develop their own practice guidelines and criteria, but it must be approved by the State and made available to the State. The Contractor must establish and maintain medical management criteria and practice guidelines in accordance with State and federal regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals and consider individual member needs. Pursuant to 42 CFR 438.210(b), the Contractor must consult with contracting health care professionals in developing practice guidelines and must have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with the provider that requested the services when appropriate. Practice guidelines and criteria must be submitted to the State for approval prior to implementation by the Contractor through the standard document review process. The Contractor must periodically review and update the guidelines and post the guidelines on their website for member and provider viewing.

If the Contractor chooses to utilize separate guidelines for physical health and behavioral health services, the Contractor shall demonstrate that the use of separate guidelines would have no negative impact on members and would not otherwise violate the Contractor's requirements under the Mental Health Parity and Addiction Parity Act (MHPAEA) as required by 42 CFR 438.910(d).

7.8.3 Special Consideration for Long Term Services and Supports (LTSS)Service Authorization

The Contractor may not interfere with the member's setting of choice once level of care is determined. For example, if a member is determined eligible for nursing facility level of care including the necessary PASSR approval, the Contractor may not deny an authorization for the member to receive necessary care in a nursing facility. Likewise, the Contractor may not deny an authorization for that same member to receive the necessary care at home instead of in a facility. This requirement only applies to a member's general preference towards facility versus non-facility care. This section does not limit the Contractor's ability to steer members to in-network providers.

7.8.4 Special Consideration for Home and Community Based Services (HCBS) Service Authorization

The Contractor's utilization management program shall include distinct policies and procedures regarding Home and Community Based Services (HCBS) and shall specify the responsibilities and scope of authority of Service Coordinators in authorizing LTSS and HCBS. The Contractor's prior authorization processes should support the provision of timely services to members and administrative efficiencies for providers with less duplication of effort and more coordinated and integrated processes and systems. The Contractor shall authorize LTSS and HCBS based on an enrollee's current needs assessment and consistent with the person-centered service plan in accordance with 42 CFR 438.210(b)(2)(iii). The prior authorization of HCBS covered benefits and services shall follow the policies and procedures as described in Section 4.0 Care Coordination. The Contractor may not require a provider to submit an additional authorization for services present in the member's person-centered service plan (the service plan is the authorization). The Contractor shall alert the relevant provider of the services approved in the person-centered service plan using the timelines specified for utilization management approvals and denials.

7.8.5 Authorization of Services and Notices of Actions

The Contractor shall have in place and follow written policies and procedures for processing authorization requests for initial and continuing authorizations of services as required by 42 CFR 438.210(b)(1). The Contractor's utilization management program policies and procedures must meet all state and federal regulations and current NCQA standards and must include appropriate timeframes for:

a. Completing initial requests for prior authorization of services;
b. Completing initial determinations of medical necessity;
c. Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per state law;
d. Notifying providers and members in writing of the Contractor's decisions on initial prior authorization requests and determinations of medical necessity following FSSA forms and templates; and
e. Notifying providers and members of the Contractor's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity.

The Contractor must provide a written notice to the member and provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. For members enrolled in an aligned DSNP the Contractor must send a single integrated decision notice in accordance with the requirements in 42 CFR 422.629. The notice must meet the requirements of 42 CFR 438.404. The notice to members must be provided at a fifth-grade reading level. The notice must be given within the timeframes described in the following paragraphs and 42 CFR 438.404(c), specifically:

a. Unless otherwise provided in 405 IAC 5-3-14 or 42 CFR 438.210(d)(1), to require a shorter timeframe, the Contractor must notify members of standard authorization decisions not pertaining to medications as expeditiously as required by the member's health condition, not to exceed seven (7) calendar days after the request for services. An extension of up to fourteen (14) calendar days is permitted if the member or provider requests an extension or if the Contractor justifies to FSSA a need for more information and explains how the extension is in the member's best interest. The Contractor will be required to provide its justification to FSSA upon request. Extensions require written notice to the member and must include the reason for the extension and the member's right to file a grievance.

b. Unless otherwise provided in 405 IAC 5-3-14, if the Contractor fails to respond to a member's prior authorization request not pertaining to medications within seven (7) calendar days of receiving all necessary documentation, the authorization is deemed to be granted.

c. For authorizations originally approved by the Contractor, if the Contractor denies continuation of services with the skilled nursing facility or long-term attendant care the Contractor must provide at least five (5) days of coverage for the services from the date of the notice of denial, to ensure the safe discharge of the member. This requirement does not apply for authorizations submitted untimely by the provider.

d. For situations in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than forty-eight (48) hours after receipt of the request for service. The Contractor may extend the forty-eight (48) hours by up to fourteen (14) calendar days if the member requests an extension or the Contractor justifies a need for

additional information and how the extension is in the best interest of the member. The Contractor will be required to provide its justification to FSSA upon request.

e. For requests related to HCBS, the contractor shall make an expedited authorization decision and notice to the member within 24 hours of the decision to deny authorization for services contained in the member's Service Plan. Under no conditions may the Contractor extend that timeframe.

f. If the Contractor extends the timeframe in accordance with 42 CFR 438.210(d)(1), it must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if they disagree with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

g. For concurrent reviews within 72 hours of a non-urgent request and within 1 business day of an urgent request.

h. For decisions to terminate, suspend or reduce previously authorized covered services at least ten (10) business days before the date of action, with the following exceptions:

    1. Notice is shortened to five (5) business days if probable member fraud has been verified by the Indiana Office of the Inspector General or Attorney General.
    2. Exceptions detailed in in 42 CFR 431.213 and 431.214
    3. Notice may occur no later than the date of the action in the event of:
        a. The death of a member;
        b. The Contractor's receipt of a signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (the member must understand the result of supplying this information);
        c. The member's admission to an institution;
        d. The member's address is unknown and mail directed to him/her has no forwarding address;
        e. The member's acceptance for Medicaid services by another local jurisdiction;
        f. The member's physician prescribes the change in the level of medical care;
        g. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions; or
        h. The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs or a member has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse actions for nursing facility transfers).

i. The Contractor shall have staff available on weekends to ensure that utilization management decisions and notifications and delivered in the timelines required in this scope of work. Contractor timeliness shall be an area of enhanced auditing by the State.

The Contractor may not retroactively deny authorization for the continuation of care unless the provider submitted the authorization untimely.

The notification letters used by the Contractor must be approved by FSSA prior to use and clearly explain the following:

- The qualifications of the reviewer;
- The guidelines used and reason for denial or approval;
- The action the Contractor or its contractor has taken or intends to take;

- The reasons for the action;
- The member's right to file an appeal with the Contractor and the process for doing so;
- After the member has exhausted the Contractor's appeal process, the notice must contain the member's right to request an FSSA Fair Hearing and the process for doing so;
- Circumstances under which expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services; and
- The provider's right for a peer-to-peer utilization review conversation with the reviewer including the process for scheduling a peer-to-peer utilization review conversation and that the provider has fifteen (15) business days request a peer-to-peer conversation. A provider must be able to schedule a specific date and time for the peer-to-peer conversation to occur.

The Contractor must report its medical necessity determination decisions, in a manner prescribed by the Reporting Manual.

7.8.6 Authorization Systems and Technology

The Contractor must accept the universal prior authorization forms established by the State with no additional information besides clinical documentation necessary to make the determination. Additionally, providers must be able to submit prior authorization, concurrent reviews, retrospective reviews, and appeals of decisions in an electronic format via a web-based system accessible through the Contractor's website. The web-based system should mimic the fields on the universal prior authorization forms established by the State and not require additional information. The Contractor's web-based system should use automation and built-in system logic (e.g., member information pre-population, and smart editing to reduce errors) to reduce administrative burden on providers.

The Contractor's utilization management system should be automated where possible to reduce burden on members and providers, e.g., interfacing with the care management system containing service plan authorizations. and automatic approvals for certain procedures with diagnoses that are consistent with the treatment.

The Contractor must track all prior authorization requests in their IT system. All notes in the Contractor's prior authorization tracking system must be signed by clinical staff and include the appropriate suffix (e.g., RN, MD, etc.). For prior authorization approvals, the Contractor shall provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the Contractor's IT system: (a) name of requester; (b) title of requester; (c) date and time of request; and (d) prior authorization number.

For all denials of prior authorization requests, the Contractor shall maintain a record of the following information, at a minimum, in the Contractor's IT system: (a) name of caller; (b) title of caller; (c) date and time of call; (d) clinical synopsis, which shall be include timeframe of illness or condition, diagnosis, and treatment plan; and (e) clinical guideline(s) or other rational supporting the denial (e.g., insufficient documentation).

Additionally, the Contractor must establish an electronic prior authorization look-up tool that provides verification of whether a service requires authorization, including but not limited to LTSS services. This look-up tool shall be easily found on the Contractor's website and not require an account to be made by the provider to access.

7.8.7 Referral Requirements

As part of the utilization management function, the Contractor must facilitate provider requests for authorization for primary and preventive care services and must assist providers in providing appropriate referrals for specialty services by locating resources for appropriate referral. The Contractor shall not require referrals for specialists or other providers, but prior authorization may be required for specialist services. In accordance with federal regulations, the process for authorization of services must comply with the following requirements:

- *Second Opinions*: In accordance with 42 CFR 438.206(b)(3), the Contractor must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a provider who is qualified to give a second opinion, the Contractor must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

- *Special Needs*: In accordance with 42 CFR 438.208(c), the Contractor must allow members with special needs, who are determined to need a course of treatment or regular care monitoring, to directly access a specialist for treatment via an established mechanism such as a standing referral from the member's PMP, if applicable, or an approved number of visits. Treatment provided by the specialist must be appropriate for the member's condition and identified needs.

- *Women's Health*: In accordance with 42 CFR 438.206(b)(2), the Contractor must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist. The Contractor must have an established mechanism to permit a female member direct access such as a standing referral from the member's PMP, if applicable, or an approved number of visits. The Contractor may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

7.8.8 Objection on Moral or Religious Grounds

If the Contractor elects not to provide, reimburse for, or provide coverage of any service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows, in accordance with 42 CFR 438.102(b):

- To FSSA with its response to the RFP;
- To FSSA if it adopts the policy during the term of the Contract;
- If the policy is approved by FSSA, to potential members before and during enrollment; and to members within ninety (90) calendar days after adopting the policy with respect to any particular service, but at least thirty (30) calendar days prior to the effective date.

7.8.9 Utilization Management Committee

The Contractor must have a utilization management committee directed by the Contractor's Medical Director. The committee is responsible for:

- Monitoring providers' requests for rendering health care services to its members;
- Monitoring the medical appropriateness and necessity of health care services provided to its members;
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed;

- Writing policies and procedures for utilization management that conform to industry standards including methods, timelines and individuals responsible for completing each task; and
- Confirming the Contractor has an effective mechanism in place for a plan provider or Contractor representative to respond within one (1) hour to all Emergency room providers twenty-four (24)-hours-a-day, seven (7)-days-a-week:
    - After the Contractor's member's initial Emergency room screening; and,
    - After the Contractor's member has been stabilized and the Emergency room provider believes continued treatment is necessary to maintain stabilization.

8.0 Program Integrity

The Indiana Office of the Attorney General, Medicaid Fraud Control Unit is the State agency responsible for the investigation of provider fraud in the Indiana Medicaid program. The OMPP Program Integrity Section (OMPP PI), is responsible for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of Medicaid-eligible beneficiaries and referring cases of suspected fraud to the MFCU for investigation. The OMPP PI Section identifies and recovers Medicaid waste and abuse. The FSSA Bureau of Investigations evaluates and investigates reports of suspected fraud by recipients of assistance programs and both government and contract employees.

The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting, including business transaction disclosure reporting (42 CFR 455.104) and shall further provide any additional information necessary for the FSSAS to perform exclusion status checks pursuant to 42 CFR 455.436. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and the terms of this Contract, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at any time upon request.

The Contractor, as well as its subcontractors and LTSS providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any services provided by excluded individuals shall be refunded to and/or obtained by the State and/or the Contractor as prescribed in Section 8.4 Program Integrity Overpayment Recovery. Where the excluded individual is the provider of services or an owner of the provider, all amounts paid to the provider shall be refunded.

The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities. Staffing levels, at a minimum, will be equal to one full-time staff member for every one hundred thousand (100,000) Medicaid members in addition to the Special Investigation Unit Manager and the Compliance Officer.

The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. The Contractor shall also provide all documentation and information requested by OMPP PI Section or required under this section and its subsections in the form and manner mandated by the OMPP PI Section.**8.1 Program Integrity Plan**

Pursuant to 42 CFR 438.608, which sets program integrity requirements, the Contractor must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The Program Integrity Plan shall serve as Contractor's compliance plan. The Program Integrity Plan shall be submitted annually and upon request by the OMPP PI Section, and updated quarterly, or more frequently if required by the OMPP Program Integrity (PI) Section. The PI

Plan and/or updates to the PI Plan shall be submitted through the reporting process to FSSA, who shall forward to the OMPP PI Section, ten (10) business days prior to scheduled meetings discussing the Plan. The Plan shall include in its PI Plan provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of Contractor's providers, vendors, and subcontractors (including but not limited to Pharmacy Benefits Managers) and Contractor itself, including:

1. Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.
2. The designation of a Special Investigation Unit Manager, a Compliance Officer and a Compliance Committee. The Plan should document that the Compliance Officer and SIU Manager shall meet with the OMPP PI Section at a minimum of quarterly and as directed by the OMPP PI Section.
3. The type and frequency of training and education for the Special Investigation Unit Manager, Compliance Officer, and the organization's employees who will be provided to detect fraud. Training must be annual and address the False Claims Act, Indiana laws and requirements governing Medicaid reimbursement and the utilization of services – particularly changes in rules, and other federal and state laws governing Medicaid provider participation and payment as directed by CMS and FSSA. Training should also focus on recent changes in rules.
4. A risk assessment of the Contractor's various fraud and abuse/program integrity process. A risk assessment shall also be submitted on an "as needed" basis or at a minimum of every six (6) months. This assessment shall also include a listing of the MCEs top three vulnerable areas and shall outline action plans mitigating such risks.
5. An organizational chart and communication plan highlighting lines of communication between the Special Investigation Unit Manager, the Compliance Officer and the organization's employees.
6. Provision for internal monitoring and auditing.
7. Procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this contract.
8. A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:
    - A list of automated pre-payment claims edits.
    - A list of automated post-payment claims edits.
    - A list of types of desk audits on post-processing review of claims.
    - A list of reports for provider profiling and credentialing used to aid program and payment integrity reviews.
    - A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.
    - A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials.
    - A list of references in provider and member material regarding fraud and abuse referrals.
    - A list of provisions for the confidential reporting of PI Plan violations to the designated person.

- A list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports.

9. Provisions ensuring that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.
10. Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance PI Plan violations.
11. Requirements regarding the reporting of any confirmed or suspected provider fraud and abuse under state or federal law to the OMPP PI Section and pursuant to Section 8.3 below.
12. Assurances that no individual who reports Contractor's potential violations or suspected fraud and abuse is retaliated against.
13. Policies and procedures for conducting both announced and unannounced site visits and field audits to providers defined as high risk (including but not limited to providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.
14. Provisions for prompt response to detected offenses, and for development of corrective action initiatives.
15. Program integrity-related goals, objectives, and planned activities for the upcoming year.

8.2 Program Integrity Operations

The Contractor shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard Medicaid funds against improper payments and unnecessary or inappropriate use of Medicaid. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected waste, fraud and abuse activities. Contractor shall have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud and abuse issues of Contractor's providers, vendors, and subcontractors (including Pharmacy Benefits Managers) and Contractor itself.

The Contractor shall immediately report all suspected or confirmed instances of waste, fraud and abuse to the FSSA and the OMPP PI Section. The Contractor shall use the Reporting Forms provided by the FSSA for all such reporting or such other form as may be deemed satisfactory. The Contractor shall be subject to non-compliance remedies under this Contract identified in Exhibit 2 for willful failure to report fraud and abuse by providers, Medicaid beneficiaries/ members, or applicants to the OMPP PI Section as appropriate. All confirmed or suspected cases of waste, fraud and abuse shall be discussed at the Managed Care-Program Integrity coordination meeting following the OMPP PI Section's receipt of the report unless otherwise directed by the OMPP PI Section.

The Contractor shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the Contractor shall not take any of the following actions as they specifically relate to Indiana claims:

- Contact the subject of the investigation about any matters related to the investigation,
- Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

The Contractor shall promptly provide the results of its preliminary investigation to the OMPP PI Section or to another agency designated by the OMPP PI Section.

The Contractor shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

The Contractor is required to conduct and maintain at a minimum the following operations and capabilities. Contractor shall conduct all operations and deploy all capabilities described below on a routine basis and as necessary for the effective reduction of Medicaid waste, fraud and abuse.

- The Special Investigation Unit within the Contractor's structure shall have the ability to make referrals to the OMPP PI Section, and accept referrals from a variety of sources including: directly from providers (either provider self-referrals or from other providers), members, law enforcement, government agencies, etc. The Contractor shall also have effective procedures for timely reviewing, investigating, and processing such referrals.
- The Contractor will suspend all payments to a provider after OMPP determines that there is a credible allegation of fraud and has provided the Contractor with written notice of a payment suspension.
- Data mining, analytics, and predictive modeling for the identification of potential overpayments and aberrant payments/providers warranting further review/investigation.
- Provider profiling and peer comparisons of all of Contractor's provider types and specialties – at a minimum annually - to identify aberrant service and billing patterns warranting further review/audit.
- Onsite Audit capability and protocols identifying how and when the Special Investigation Unit shall conduct such onsite audits of providers.
- Medical claim audit capabilities sufficient to enable the Special Investigation Unit to audit any payment issued to any provider. This includes utilizing medical record reviewers, clinicians, coding specialists, accountants, and investigators needed for review of payments to any provider/provider type.
- Member service utilization analytics to identify members that may be abusing services. Contractor shall submit to FSSA for approval the criteria utilized for its review of its members and the referral of members to the Right Choices Program.

8.3 Program Integrity Reporting

The Contractor shall cooperate with all appropriate state and federal agencies, including the Indiana MFCU and the OMPP PI Section, in investigating fraud and abuse. The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21). Contractor shall provide an Audit Report to FSSA and the OMPP PI Section. The Audit Report documents all provider and member-specific program integrity activities of Contractor (i.e., the specific application of Program Integrity Plan provisions to identify specific provider and member waste, fraud and abuse), as documented below.

On a quarterly basis, and as otherwise directed by the OMPP PI Section, the Contractor shall submit a detailed Audit Report to FSSA which outlines the Contractor's program integrity-related activities, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives. The Audit Report shall specify current audits, reviews, claim denials, and investigation activity of the section, a summary of the reason for the audit/investigative activity, the disposition of any such completed activity (including detailed overpayment amounts identified or recouped), and projected upcoming activity for the following quarter. The Audit Report should also specify individual provider recoupment, repayment

schedules, and actions taken for each audit or investigation. The quarterly progress report must identify recoupment totals for the reporting period. The Audit Report shall also identify projected upcoming activity, including the top twenty (20) providers on Contractor's list for audit, and the type(s) of audit(s) envisioned.

The OMPP PI Section shall review and approve, approve with modifications, or reject the Audit Report and specify the grounds for rejection. Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the OMPP PI Section) must also be submitted in the Audit Report.

In accordance with 42 CFR 438.608(d)(3), the Contractor report annually to the State on the recoveries of overpayments.

8.4 Program Integrity Overpayment Recovery

The Contractor has primary responsibility for the identification of all potential waste, fraud and abuse associated with services and billings generated as a result of this Contract.

In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by the OMPP PI Section, FSSA may recover any identified overpayment directly from the provider or may require Contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Section. The OMPP PI Section may also take disciplinary action against any provider identified by Contractor or the OMPP PI Section as engaging in inappropriate or abusive billing or service provision practices.

If a fraud referral from Contractor generates an investigation and/or corresponding legal action results in a monetary recovery to IHCP, the reporting Contractor will be entitled to share in such recovery following final resolution of the matter (settlement agreement/final court judgment) and following payment of recovered funds to the State of Indiana. The Contractor's share of recovery will be as follows:

- From the recovery, the State (including the IMFCU) shall retain its costs of pursuing the action, including any costs associated with OMPP PI Section operations associated with the investigation, and its actual documented loss (if any). The State will pay to the Contractor the remainder of the recovery, not to exceed the Contractor's actual documented loss. Actual documented loss of the parties will be determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.
- If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the Contractor about potential settlement. The State may consider the Contractor's preferences or opinions about acceptance, rejection or the terms of a settlement, but they are not binding on the State.
- If final resolution of a matter does not occur until after the Contract has expired, the preceding terms concerning disposition of any recovery and consultation with the Contractor shall survive expiration of the Contract and remain in effect until final resolution of a matter referred to the IMFCU by the Contractor under this section.

If the State makes a recovery from a fraud investigation and/or corresponding legal action where the Contractor has sustained a documented loss but the case did not result from a referral made by the Contractor, the State shall not be obligated to repay any monies recovered to Contractor, but may do so at its discretion. Funds recovered as a result of a multi-state fraud investigation/litigation, however, will be shared with Contractor as prescribed for funds recovered as a result of Contractor's fraud referral absent extenuating circumstances.

The Contractor is prohibited from the repayment of state-, federally-, or Contractor-recovered funds to any provider when the issues, services or claims upon which the repayment is based meets one or more of the following:

- The funds from the issues, services, or claims have been obtained by the State or federal governments, either by the State directly or as part of a resolution of a state or federal audit, investigation and/or lawsuit, including but not limited to False Claims Act cases;
- When the issue, services, or claims that are the basis of the repayment have been or are currently being investigated by the OMPP PI Section, the federal Medicaid Integrity Contractor (MIC), Contractor, Indiana MFCU, or Assistant United States Attorney (AUSA), are the subject of pending federal or State litigation, or have been/are being audited by the State Recovery Audit Contractor (RAC).

This prohibition described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The Contractor shall check with the OMPP PI Section before initiating any repayment of any program integrity related funds to ensure that the repayment is permissible.

The Contractor will have policies and procedures in place to fully comply with 42 CFR 438.608. The Contractor must maintain relevant documentation for a minimum of seven (7) years. Quarterly and annual reporting of recoveries will be made in accordance with the guidance in the MCE Reporting Manual.

8.5 Auditing Program Integrity Operations

The OMPP PI Section may conduct audits of Contractor's Special Investigation (SI) Unit activities to determine the effectiveness of Contractor's operations. Such audit activities may include conducting interviews of relevant staff, reviewing all documentation and systems used for Special Investigation Unit activities, and reviewing the SI Unit's performance metrics. The OMPP PI Section may issue a corrective action or performance improvement plan and outline timelines for improvement measures. The failure to adhere to operational improvement measures may result in the State's imposing liquidated damages up to the amount of overpayments recovered from Contractor's providers by OMPP PI Section audits for the preceding calendar year, or imposing other non-compliance remedies including liquidated damages as authorized by Exhibit 2.

8.6 Long Term Services and Supports

In addition to the requirements in this section, the Contractor shall ensure:

- As part of monitoring, auditing and investigating network providers and subcontracted services to detect fraud, abuse and improper payments, the Contractor shall have mechanisms in place to review documentation maintained by providers of LTSS to ensure compliance with the billing requirements.
- If a home health or personal service agency (as defined by IC 16-27-1 and IC16-27-4-5) or a Residential Care Facility also known as an assisted living facility licensed under IC 16-28-2, or a health facility also known as nursing facility and also licensed under IC 16-28-2, or a hospice agency licensed under 16-25-3 determines it is unable to continue providing services to a member because of an action under Indiana law, per IC 16-27-4, the Contractor must cooperate in supporting the member in utilizing a different provider of the member's choice within the Contractor's network.
- In the event of a sanction of a home health or personal service agency or any other HCBS provider per 455 IAC 2-6-5(c)(2), a suspension of participation, or a termination of participation of a home health, agency personal services agency, or residential care facility by FSSA or from the Contractor, the Contractor must inform FSSA of the number of members impacted and the Contractor must contact members to ensure that members continue to receive needed care and have been given choice of provider within the Contractor's network.

- Ensure that for personal services as defined by IC 16-27-4-4, home health, personal care, and hospice agencies, nursing and assisted living facilities, and any other HCBS provider per 455 IAC 2-6-2(a)(3), must obtain either an expanded criminal history check as defined at IC 20-26-2-1.5; or a national criminal history background check as defined at IC 10-13-3-12.(5) Have provisions in its Compliance Plan regarding instructions to Home Health, Hospice, Assisted Living, Nursing Facility, and Personal Care Service providers to maintain written policies and procedures of their business model. The policy and procedures shall include at a minimum; roles and responsibilities of key personnel, organizational chart, succession planning, ownership, background checks for all personnel, fraud, waste, and abuse reporting protocols, and a plan for fraud, waste, and abuse employee training as required by Deficit Reduction Act of 2005 Section 6032. 2.20.3.10.
- Have provisions in its Compliance Plan to perform a coordinated audit of a sampling of home health, personal care, hospice, nursing facilities, and assisted living providers to ensure providers are only audited by one Managed Care Organization. The results of the audits will be submitted annually to FSSA with the Compliance Plan.

9.0 Information Technology (IT) Systems

The Contractor must have an Information Technology (IT) systems sufficient to support the [MLTSS Program Name] requirements, and the Contractor must be prepared to submit all required data and reports in the format specified by FSSA. This may include, at the State's discretion, an administrative data extract in a prescribed format outlined in the Reporting Manual. The Contractor must maintain an IT system with capabilities to provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility in accordance with 42 CFR 438.242, and perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Section. The Contractor's IT Systems must support provider electronic submission of authorization requests, authorization appeals, claims, claim disputes and claim appeals.

In the event the State's technical requirements require amendment during the term of the Contract, the State will work with Contractors in establishing the new technical requirements. The Contractor must be capable of adapting to any new technical requirements established by the State, and the State may require the Contractor to agree in writing to the new requirements. After the Contractor has agreed in writing to a new technical requirement, any Contractor-initiated changes to the requirements shall require FSSA approval and FSSA may require the Contractor to pay for additional costs incurred by the State in implementing the Contractor-initiated change.

The Contractor shall develop processes for the development, testing, and promotion of system changes and maintenance. The Contractor shall notify FSSA at least thirty (30) calendar days prior to the installation or implementation of minor software and hardware changes, upgrades, modifications, or replacements. The Contractor shall notify FSSA at least (90) calendar days prior to the installation or implementation of major software or hardware changes, upgrades, modifications, or replacements. "Major" changes, upgrades, modifications or replacements are those that impact mission-critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment, and data management, encounter data management, and any other processing affecting the Contractor's capability to interface with the State or the State's contractors. The Contractor shall ensure that system changes or system upgrades are accompanied by a plan which includes a timeline, milestones and adequate testing to be completed prior to implementation. The Contractor shall notify and provide such plans to FSSA upon request in the timeframe and manner specified by the State.

The Contractor must have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164). The Contractor's IT systems must support HIPAA Transaction and Code Set requirements for electronic health information data exchange, NPI requirements and Privacy

and Security Rule standards. The Contractor's IT plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308);
- Physical safeguards (45 CFR 164.310); and
- Technical safeguards (45 CFR 164.312).

The Contractor must make data available to FSSA and, upon request, to CMS. In accordance with 42 CFR 438, subpart H, the Contractor must submit all data, including encounter claims, under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the Contractor's data. The Reporting Manual will provide an attestation form which must be utilized by the Contractor.

The Contractor must comply with all Indiana Office of Technology (IOT) standards, policies and guidelines, which are available online at https://secure.in.gov/iot/policies-procedures-and-standards/. All hardware, software and services provided to or purchased by the State shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d) and IC 4-13.1-3. Any deviation from these architecture requirements must be approved in writing by IOT in advance.

In addition to the IOT policies, the Contractor shall comply with all FSSA Application Security Policies. Any deviation from the policies must be approved in writing from FSSA. Furthermore, Contractors must be willing to accept FSSA's Confidentiality, Security and Privacy of Personal Information contractual terms.

9.1 Testing with the State

The Contractor shall complete various testing with the Indiana Medicaid Management Information System (CoreMMIS) as directed by the State (including but not limited to system integration testing, user acceptance testing, and end-to-end testing). The Contractor shall also comply with testing requirements with any additional systems which require data exchange with the State or its designee, in the timeframe and method determined by the State.

9.2 Master Test Plan

Software testing is the process of evaluation to detect differences between given input and expected output. Testing assesses the quality of the product. Software testing is a verification and validation processes that should be done during the development process.
The Contractor's Master Test Plan should be fully inclusive of the testing phases listed below. Any deviations from this list of phases (additions or deletions) will need to be explained and justified in the State approved Contractor's Master Test Plan.

- Unit Testing (UT)
  Defined as testing conducted on individual units (components) of an integrated system, designed to validate that each unit performs as designed.
- System Integration Testing (SIT)
  Defined as testing conducted on a complete, integrated system to evaluate the system's compliance with its specified requirement.
- External Contractor and/or Partner Testing
  Defined as independent testing to demonstrate that the applicable phase of the system and the system as installed conforms to the application system specifications.
- User Acceptance Testing (UAT)
  Defined as acceptance testing often done by the customer to ensure that the delivered product

meets the requirements and works as the customer expected. The Contractor is required to provide 'proof of life' (aka ‘proof of concept’) demonstrations for all systems prior to UAT.

- End-to-End (E2E) Testing
  Defined as testing that the flow of an application is performing as designed from start to finish to identify system dependencies and ensure that the right information is passed between various system components and systems.
- Regression Testing
  Defined as testing after modification of a system, component, or a group of related units to ensure that the modification is working correctly and is not damaging or imposing other modules to produce unexpected results.
- Stress / Volumetric Testing
  Defined as testing to evaluate how the application or system behaves under unfavorable conditions and how it recovers when going back to normal usage. Stress Testing is conducted at upper and beyond limits of the specifications.
- Security Testing
  Contractor may be subject to either the creation of, or full cooperation with, Security Assessment or testing as prescribed by the State. This may include Penetration Testing or SOC-1 audits.

  The State requires the following specific criteria to be formally adopted, included, or executed as part of the contractor’s holistic testing plan:

    - Each Test Plan shall include, but not be limited to, the following:
        - Testing Strategy, including dates and participants
        - Test Scenarios and Cases
        - Full Requirement Tracing
        - Input Data
        - Expected Results
        - Actual Results
        - Status
        - Secondary Result Validation
    - Provide for at least a month between testing completion and Go-Live.
    - Access must be directly provided to the correct testing environments at no cost to any participant internal or external to the contractor.
    - Participate in test phases including other parties (such as Contractor or User Acceptance testing) not just by providing access, but by developing test plans and scenarios for these phases as well and providing the required input data and unique configurations to support all internal and external test cases.
    - Cooperation and collaboration with all contractors, stakeholders and testing partners is required by the State to ensure each test phase is successful. This collaboration shall extend to test phases run by other partners external to those managed by the Contractor in order to ensure the success of the effort overall.

Furthermore, the State requires that contractors adhere to its criteria for and definition of defects listed below in Table 1, their severities, and the defined actions required by Severity. The State has unilateral authority to assign or change a defect level:

Table 1, Defect Severity Definitions and Required Actions

Severity	Definition / Criteria for Assignment	Required Schedule / Action to Resolve
1	Catastrophic - Functionality causes critical impact / system failure. Any defect that causes major system impacts or interface issues and is not acceptable for production. A serious deviation from requirements which prohibits the stakeholder from accurately completing a major piece of functionality.	Any Severity 1 defects must be resolved, re-tested and the fix confirmed prior to implementation.
2	Major - Major functions are/would be disabled; no workaround exists.	Any Severity 2 defects must be resolved, re-tested and the fix confirmed prior to implementation
3	Medium - Major functions are/would be disabled; workaround available and acceptable to the State. A minor deviation from requirements which prohibits the stakeholder from completing a minor piece of functionality accurately and there may or may not be an appropriate workaround acceptable to the State. Note: The State may make determinations that certain errors classified as “Minor deviations” are to be corrected before the system is ready for production.	Any Severity 3 defects must have a state-approved workaround, including detailed operating procedures for the intervention and an implementation plan for the automated fix. Final fix must be re-tested, implemented, and confirmed within 90 days of Go Live
4	Minor – minor functions are/would be disabled	Any severity 4 defects must be resolved, re-tested, implemented and confirmed within 180 days of Go Live
5	Cosmetic – a deviation from requirements, which does not prohibit processing of a piece of functionality or indicates an internal issue that is not considered a defect in the system, but requires attention to ensure quality of the system.	Any severity 5 defects must be resolved, re-tested, implemented and confirmed within 365 days of Go Live

9.3 Business Contingency and Disaster Recovery Plans

IT system contingency planning shall be developed in accordance with the requirements of this section and with 45 CFR 164.308, which relates to administrative safeguards. Contingency plans shall include: Data Backup plans, Disaster Recovery plans and Emergency Mode of Operation plans. Application and Data Criticality analysis and Testing and Revisions procedures shall also be addressed within the Contractor’s contingency plan documents. The Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or

alternative location under emergency conditions within twenty-four (24) hours of identification of a disaster. The Contractor shall protect against hardware, software and human error. The Contractor must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. The Contractor shall maintain full and complete back-up copies of data and software and shall back up on tape or optical disk and store its data in an off-site location approved by FSSA.

For purposes of this Scope of Work, “disaster” means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Contractor’s or its subcontracting entities’ IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. The Contractor shall take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the Contractor will jointly determine when unscheduled system downtime will be elevated to a “disaster” status. Disasters may include natural disasters, human error, computer virus or malfunctioning hardware or electrical supply. The Contractor must take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the Contractor will jointly determine when unscheduled system downtime will be elevated to a “disaster” status.

The Contractor shall notify FSSA, at minimum, within two (2) hours of discovery of a disaster or other disruptions in its normal business operations. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, encounter data management, and any other processing affecting the Contractor’s capability to interface with the State or the State’s contractors. Depending on the anticipated length of disruption, FSSA, in its discretion, may require the Contractor to provide FSSA a detailed plan for resuming operations. In the event of a catastrophic or natural disaster (including, but not limited to, fire, flood, earthquake, storm, hurricane, war, invasion, act of foreign enemies, or terrorist activities), the Contractor shall resume normal business functions at the earliest possible time, not to exceed thirty (30) calendar days. If deemed appropriate by the State, the Contractor shall coordinate with the State fiscal agent to restore the processing of claims by CoreMMIS if the claims processing capacity cannot be restored within the Contractor’s system. In the event of other disasters or system unavailability caused by the failure of systems and technologies within the Contractor’s span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply), the Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten (10) calendar days.

The Contractor and [MLTSS Program Name] subcontractors’ responsibilities include, but are not limited to:

- Supporting immediate restoration and recovery of lost or corrupted data or software.
- Establishing and maintaining, in an electronic format, a weekly back-up and a daily back-up that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations and user documentation.
- Demonstrating an ability to meet back-up requirements by submitting and maintaining Data Backup and Disaster Recovery Plans that address:

    1. Checkpoint and restart capabilities and procedures;
    2. Retention and storage of back-up files and software;
    3. Hardware back-up for the servers;
    4. Hardware back-up for data entry equipment; and
    5. Network back-up for telecommunications.

- Developing coordination methods for disaster recovery activities with FSSA and its contractors to ensure continuous eligibility, enrollment and delivery of services.
- Providing the State with business resumption documents, reviewed and updated at least annually, such as:
    1. Disaster Recovery Plans
    2. Business Continuity and Contingency Plans
    3. Facility Plans
    4. Other related documents as identified by the State

At no additional charge to the State, the Contractor shall be required to have in a place a comprehensive, fully tested IT business continuity/disaster recovery plan (ITBCP) that, at minimum, meets the requirements of NIST SP800-34. The ITBCP shall be submitted to the State within ninety (90) calendar days of Contract award with, at minimum, annual updates thereafter. The Contractor shall make reasonable updates and changes to its ITBCP as requested from time-to-time by the State or as otherwise may be required by applicable federal or State laws and regulations:

- The ITBCP will, at a minimum, meet the requirements of NIST SP800-34.
- The State and the Contractor will mutually agree on reasonable Recovery Point Objectives and Recovery Time Objectives reflective of the State's business requirements and the critical nature of the Contractor's systems and services in support of the associated State business operations:
    1. At a minimum, the Recovery Time Objectives will be no more than forty-eight (48) hours;
    2. At a minimum, the Recovery Point Objectives will be no more than twenty-four (24) hours; and
    3. These Objectives will be reviewed and, as necessary, modified on an annual basis.
- The Contractor will coordinate its ITBCP with FSSA's own IT business continuity/disaster recovery plans, including other State solutions with which the Contractor's system interfaces to assure appropriate, complete, and timely recovery:
    1. The Contractor agrees to coordinate the development, updating, and testing of its ITBCP with the State in the State's development, updating, and testing of its Continuity of Operations Plan (COOP), as required by State policy and Homeland Security Presidential Directive (HSPD) 20.
- The ITBCP will be based on the agreed upon Recovery Point Objectives and Recovery Time Objectives, and a comprehensive assessment of threat and risk to be performed by the Contractor, with such threat and risk assessment updated on no less than annually by the Contractor (to reflect technological, Contractor business, and State business operations changes, and other appropriate factors).
- The State expects the Contractor's ITBCP to be tested by the Contractor no less than annually, with such testing being comprehensive in nature and scope assuring point-to-point testing in meeting the agreed upon Recovery Point Objectives and Recovery Time Objectives.
    1. The first test of the Contractor's ITBCP is expected to be performed within ninety (90) calendar days of the State's award of a contract to the Contractor.

- The Contractor will provide the State with an annual report regarding the Contractor's (no less than) annual testing and updating of its ITBCP, including the results of the annual test, including failure points and corrective action plans.

  The first such report is expected within thirty (30) calendar days of the Contractor's completion of its first test of its ITBCP.

- The Contractor will submit to the State a copy of its ITBCP, including annual updates.

  1. The first copy of the ITBCP will be expected within ninety (90) calendar days of the State's award of a contract to the Contractor.

- The Contractor further agrees to make reasonable updates and changes to its ITBCP as requested from time-to-time by the State or as otherwise may be required by applicable federal or state laws and regulations.

9.4 Member Enrollment Data Exchange

The Contractor shall be responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member. The Contractor shall reconcile its eligibility and capitation records monthly. If the Contractor receives either enrollment information or capitation, the Contractor is financially responsible for the member. If the Contractor discovers a discrepancy in eligibility or capitation information, the Contractor must notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records. The Contractor must return any capitation overpayments to FSSA within forty-five (45) calendar days of discovering the discrepancy. If the Contractor receives either enrollment information or capitation for a member, the Contractor is financially responsible for the member.

The Contractor must accept enrollment data in electronic format, currently via secure file transfer protocol ("FTP"), as directed by FSSA and as detailed in the Indiana Health Coverage Program Companion Guide – 834 Contractor Benefit Enrollment and Maintenance Transaction ("834 Companion Guide), which shall be updated by FSSA. FSSA reserves the right to amend the 834 Companion Guide during the Contract term. The current 834 Companion Guide is provided in the Bidders' Library as an example only. The Contractor is responsible for loading the eligibility information into its claims system within five (5) calendar days of receipt. In addition, the Contractor's IT systems must accommodate the State's member identification number (MID) for each member and the master client index (MCI).

The Contractor's information systems must accommodate the State's 12-digit member identification number (MID) for each member.

9.5 Provider Network Data

The Contractor shall submit provider network information to the State fiscal agent via the IHCP Provider Healthcare Portal. The Contractor shall keep provider enrollment and disenrollment information up-to-date. The Contractor shall enter updates into the Portal no less frequently than on the 1st and 15th day of each month, or as otherwise directed by the State. More information regarding provider network data will be available in the [MLTSS Program Name] Policies and Procedures Manual. The Contractor must provide single sign-on for providers to access the Provider Healthcare Portal.

9.6 Health Information Technology and Interoperability

Contracts shall comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations. Compliance includes meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations. Contractors shall transmit/receive from/to its providers, subcontractors, clearinghouses, and the State all transactions and code sets required by the

HIPAA/HITECH regulations in the appropriate standard formats, utilizing appropriate and adequate safeguards.

Contractors shall:

a. Create and adopt policies and procedures to periodically audit adherence to all HIPAA/HITECH regulations, and for which Contractor acknowledges and promises to perform, including but not limited to, the following obligations and actions:

b. Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint, and breach notification;

c. Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties prior to the HIPAA/HITECH implementation deadlines and at appropriate intervals thereafter;

d. Track training of Contractor staff and employees and maintain signed acknowledgements by staff and employees of the Contractor's HIPAA/HITECH policies;

e. Obtain a third (3rd) party certification of their HIPAA standard transaction compliance ninety (90) calendar days before the start date of operations, if applicable, and upon request by the State.

f. Notify FSSA within one (1) business day upon discovery of a HIPAA or other security breach.

Contractors are required to implement and maintain systems that meet the CMS Interoperability and Patient Access requirements in 42 CFR 438.242, 42 CFR 457.1233; 42 CFR 457.760, 42 CFR 438.62, and 42 CFR 438.10 introduced in the Interoperability and Patient Access Final Rule. This includes but is not limited to patient access and provider directory APIs and payer to payer data exchanges.

Contractors should develop, implement and participate in HIT and data sharing initiatives in order to improve the quality, efficiency and safety of health care delivery in Indiana. The Contractor shall also cooperate and participate in the development and implementation of future FSSA-driven HIT initiatives.

The Contractor shall join and maintain access to the Indiana Health Information Exchange (IHIE) to enhance its capacity and effectiveness in coordinating care for members as well as drive ongoing improvement to service transparency. The State reserves the right to require the Contractor to provide updates on how the Contractor is utilizing IHIE (e.g., Admission, Discharge, and Transfer (ADT) Alerts or CareWeb for care management purposes). The State reserves the right to require the Contractor to integrate utilization of IHIE into its practices with reasonable advance notice.

Contractors should develop and collaborate on strategies to participate and motivate non-participating providers to take part in and benefit from HIT. Strategies may include contractually requiring providers to participate and/or offering subsidized funding or other non-financial incentives.

The following are examples of HIT initiatives that the Contractor should actively be involved in, or otherwise have a plan to participate in:

a. **Electronic Medical Record (EMR).** An electronic health record is a digital version of a patient's paper chart that contains medical and treatment histories of patients. EMRs are real-time patient centered records that make information available instantly and securely to authorized users. They are built to share information with other health care providers and organizations in order to coordinate information for and from all clinicians involved in a patient's care such as: medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results. Appropriate technical, administrative, and physical safeguards should also be in place to protect patient health information contained in the EMR. To ensure interoperability among providers including laboratory, pharmacy, radiology, inpatient hospital/surgery center, outpatient clinical

care, home health, public health and others, organizations at the national level (including the Health IT Standards Panel and the Certification Commission for Health IT) are working to develop standards related to IT architecture, messaging, coding, and privacy/security and a certification process for technologies. The Contractor is strongly encouraged to use these standards in developing their electronic data sharing initiatives.

b. **Electronic Prescribing.** Electronic Prescribing is the ability to generate and transmit permissible prescriptions electronically. In 2017 Indiana implemented a statewide, comprehensive platform for healthcare professionals to review patients' controlled-substance prescription history more quickly and efficiently. This platform supports Indiana's Prescription Drug Monitoring Program (INSPECT) and transfers data into electronic health records and pharmacy management systems. Statewide integration of the INSPECT platform is a key component of Indiana's ongoing efforts to attack the opioid crisis.

c. **Inpatient Computerized Provider Order Entry (CPOE).** CPOE refers to a computer-based system of ordering diagnostic and treatment services, including laboratory, radiology and medications. A basic CPOE system promotes legible and complete order entry and can provide basic clinical decision support such as suggestions for drug doses and frequencies. More advanced CPOE systems can integrate with an EMR for access to a patient’s medical history.

d. **Health Information Exchanges (including regional health information organizations – RHIOs).** These exchanges, such as the Indiana Health Information Exchange, allow participating providers to exchange clinical data electronically. The capacity of health information exchanges varies. Some initiatives provide electronic access only to lab or radiology results, while others offer access to shared, fully integrated medical records.

e. **Benchmarking.** Contractors can pool data from multiple providers and “benchmark” or compare metrics related to outcomes, utilization of services and populations. Practice pattern analysis, with appropriate risk adjustment, can help to identify differences in treatment of patients and best practices. Information can be shared with Contractors and providers to help them identify opportunities for improvement or can be linked to pay for performance initiatives.

f. **Telehealth**. Telehealth allows provider-to-provider and provider-to-member live interactions and is especially useful in situations where members do not have easy access to a provider, such as for members in rural areas. Providers also use telehealth to consult with each other and share their expertise for the benefit of treating complex patients in [MLTSS Program Name]. Contractors develop reimbursement mechanisms to encourage appropriate use of telehealth.

g. **Mobile and Self-Service Technology.** The Contractor is encouraged to utilize mobile and self-service technology in delivering services to members. This includes, but is not limited to, remote monitoring devices to enable members to record health measures for delivery to the Contractor and/or physician practices and medication and appointment reminders through personalized voice or text messages.

h. **Admission, Discharge, and Transfer (ADT) alerts**. ADT alerts are automatic electronic notifications of admissions, discharges, and transfers that are sent to a patient’s primary care physician or other healthcare provider. Implementing ADT alerts help to reduce avoidable hospital readmissions and improves care transitions and coordination. The Contractor will promote provider utilization of ADT alerts and integrate their monitoring into health plan operations and delivery of care.

9.7 Claims Processing

9.7.1 Claims Processing Capability

The Contractor shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems to meet the requirements of section 1903(r)(1)(F) of the Act [42 CFR 438.242(b)(1); Section 6504(a) of the ACA; section 1903(r)(1)(F) of the Act].

The Contractor shall demonstrate and maintain the capability to process and pay provider claims for services rendered to the Contractor's members, in compliance with HIPAA, including National Provider Identifier (NPI) requirements. The Contractor shall be able to price specific procedures or services (depending on the agreement between the provider(s) and the Contractor) and to maintain detailed records of remittances to providers.

The Contractor shall ensure that provider submission requirements are not burdensome and align with standard billing practices and IHCP guidance. Communication to both in and out-of-network providers shall be effective and efficient, aiming to simplify and streamline the provider experience. Contractors shall continually assess administrative billing requirements to identify onerous practices in need of change.

Contractors shall employ a local Provider Claims Educator as specified in Section 2.4 to work collaboratively to educate LTSS providers transitioning from fee-for-service reimbursement to managed care. The Contractor shall implement claim requirements and processing rules that are consistent with IHCP manuals, modules, and bulletins. The Contractor must audit and test the claims processing system to ensure the correct use of HCBS procedure codes and modifiers for services included in the LTSS program and adhere to other auditing requirements as noted in Section 9.7.7. The Contractor shall offer provider participation in testing and auditing for accurate payment to LTSS providers. Contractors shall report to FSSA on their collaborative efforts at least ninety (90) days prior to initial contract implementation.

In accordance with Section 2.9, FSSA must pre-approve the Contractor's delegation of any claims processing function to a subcontractor, such as but not limited to a Dental Benefits Manager or Transportation Broker. The Contractor must submit a request and a plan of implementation to FSSA at least sixty (60) days prior to planned implementation and secure FSSA's approval of any change to sub-contracting arrangements for claims processing.

The Contractor shall use all applicable National Correct Coding Initiative (NCCI) edits in the processing of claims, except where State policy requires payment methodologies that contradict with NCCI edits. The Contractor shall use code sets and standards established and maintained by FSSA.

The Contractor shall develop policies and procedures to monitor claims adjudication accuracy and shall submit its policies and procedures for monitoring its claims adjudication accuracy to FSSA for review and approval.

The Contractor shall have written policies and procedures for registering and responding to claims disputes for both in-network and out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6 and as required in Section 6.11.3 Provider Dispute Resolution.

Provider advances, loans, and loan guarantees over $50,000 per Provider Tax Identification Number (TIN) within a contract year, shall be submitted to FSSA for approval prior to payment. The request shall include a letter of explanation including the provider name and ID number, cause resulting in the need, including any mitigation strategies implemented prior to the request,

process for repayment including timeline, corrective action that will be implemented to avoid future occurrences, the total advance or loan amount and range of dates for the impacted claims.

9.7.2 Compliance with State and Federal Claims Processing Regulations

The Contractor shall have a claims processing system to support electronic claims submission for both in- and out-of-network providers. The Contractor's system must process all claim types such as professional and institutional claims. The Contractor shall comply with the claims processing standards and confidentiality standards under IC 12-15-13-1.6 and IC 12-15-13-1.7, IHCP claim processing set up detailed in modules, banners, and bulletins, and any applicable federal regulations, including HIPAA regulations related to the confidentiality and submission requirements for protected health information (PHI).

Additionally, the Contractor must permit the ICD code R69 is an acceptable diagnosis code for members receiving Home and Community Based Services through the HCBS.

The Contractor shall ensure that communication with providers, particularly out-of-network providers, and submission requirements are efficient and not burdensome for any providers. The Contractor shall be prohibited from requiring out-of-network providers to establish a Contractor-specific provider number to receive payment for claims submitted. The Contractor shall not require providers to bill using any number other than the FSSA assigned Member ID number.

9.7.3 Claims Payment Timelines

The Contractor shall pay providers for covered medically necessary services rendered to the Contractor's members in accordance with the standards set forth in IC 12-15-13-1.5, 12-15-13-1.6 and IC 12-15-13-1.7, unless the Contractor and provider agree to an alternate payment schedule and method. The Contractor shall also abide by the specifications of 42 CFR 447.45(d)(5) and (d)(6), which require the Contractor to ensure that the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

The Contractor shall pay or deny electronically filed clean claims within twenty-one (21) calendar days of receipt. A "clean claim" is one in which all information required for processing the claim is present. The Contractor shall pay or deny clean paper claims within thirty (30) calendar days of receipt. If the Contractor fails to pay or deny a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, the Contractor shall also pay the provider interest at the rate set forth in IC 12-15-21-3(7)(A). The Contractor shall pay interest on all clean claims paid late (i.e., in- or out-of-network claims) and payments made inaccurately (paid upon the claim once adjudicated appropriately) for which the Contractor is responsible, unless the Contractor and provider have made alternate written payment arrangements. Unclean claims must be rejected or denied within thirty (30) days of receipt.

The out-of-network provider filing limit for submission of claims to the Contractor is six (6) months from the date of service. This conforms with the filing limit under the Medicaid State Plan (42 CFR 447.45(d)(4)). The in-network provider filing limit is established in the Contractor's provider agreements pursuant to the guidelines set forth in Section 4.9, which generally require in-network providers to submit claims within ninety (90) calendar days from the date of service. Timely filing limits are automatically waived in the instances of eligibility updates/ retroactivity, agency error, or any other condition established by FSSA in rule or policy. In addition, in accordance with 42 CFR 447.45(d)(4)(ii), if a claim for payment under Medicare has been filed in a timely manner, the Contractor may pay a claim relating to the same services within six (6) months after the provider receives notice of the disposition of the Medicare claim. The Contractor's IT systems must allow for the bypassing of timely filing limits or indication of alleged waiver for these established conditions that does not solely rely on the appeals or grievance processes outlined in this Contract.

The Contractor shall meet the requirements set forth in IC 27-13-36.2-3 and notify providers of deficiencies in claims within the set timelines in State statute.

All providers must be offered on their provider agreement the option to select Electronic Fund Transfer (EFT) for provider payments. The Contractor shall develop a plan to issue payments predominantly via EFT and submit to the State for approval. The Contractor shall pay claims via EFT and check runs at least weekly.

The Contractor shall not violate the claims payment provisions and timeframes that apply to accident and sickness insurers and HMOs under IC 27-8-5.7.

9.7.4 Rate Update Timeliness

The Contractor shall have policies and procedures in place to load new fee schedules and fee schedule updates from FSSA into their claims processing systems. The Contractor shall update fee schedules within thirty (30) days of the fee schedule effective date or date of notice of the fee schedule change, whichever is later. The Contractor shall reprocess claims back to the effective date of the fee schedule change within 30 days of loading the updating the fee schedule. Failure to adhere to this requirement will result in corrective action, as described in Exhibit 2 Contract Compliance and Pay for Outcomes.

9.7.5 Medicaid National Correct Coding Initiative (NCCI)

The Contractor shall use all applicable National Correct Coding Initiative (NCCI) edits in the processing of claims, except where State policy requires payment methodologies that contradict with NCCI edits.

The Contractor must include the following methodologies to correctly pay claims including but not limited to:

- Medicaid National Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services,
- Multiple Procedure/Surgical Reductions, and
- Global Day E & M Bundling standards.

The Contractor’s claims payment system must be able to assess and/or apply data related edits including but not limited to:

a. Benefit Package Variations,
b. Timeliness Standards,
c. Data Accuracy,
d. Adherence to FSSA established code sets and standards Policy,
e. Provider Qualifications,
f. Member Eligibility and Enrollment, and
g. Over-Utilization Standards.

Disclosure of information contained in the Medicaid National Correct Coding Initiative (NCCI) files shall be limited to only those responsible for the implementation of the quarterly State Medicaid NCCI edit files. Disclosure shall not be made prior to the start of the new calendar quarter.

After the start of the new calendar quarter, the Contractor may disclose only non-confidential information contained in the Medicaid NCCI edit files that is also available to the general public found on the Medicaid NCCI webpage. The Contractor agrees to use any non-public information from the quarterly State Medicaid NCCI edit files only for any business purposes directly related to the implementation of the Medicaid NCCI methodologies in the Indiana.

New, revised, or deleted Medicaid NCCI edits shall not be published or otherwise shared by the Contractor with individuals, medical societies, or any other entities unless they were a Contracted Party prior to the posting of the Medicaid NCCI edits on the Medicaid NCCI webpage. Implementation of new, revised, or deleted Medicaid NCCI edits shall not occur prior to the first day of the calendar quarter. Only FSSA has the discretion to release additional information for selected individual edits or limited ranges of edits from the NCCI files shared with the Contractor. FSSA will impose penalties, up to and including loss of Contract, for violations of this confidentiality agreement relating to use of the Medicaid NCCI files.

9.7.6 Remittance Advice Requirements

The Contractor must produce a remittance advice related to the Contractor's payments and/or denials to providers and each must include at a minimum:

a. Appropriate explanatory remarks related to a payment or reason(s) for denials and adjustments,

b. A detailed explanation/description of all denials, payments and adjustments,

c. The amount billed,

d. The amount paid,

e. Application of COB and copays, and

f. Provider rights for claim disputes.

Additionally, the Contractor must include information in its remittance advice which informs providers of instructions and timeframes for the submission of claim disputes and corrected claims. The Contractor must include contact information for local provider relations team in addition to instructions and timeframes for claim disputes and corrected claims. All hard copy remittance advices must describe this information in detail. Electronic remittance advices must either direct providers to the link where this information is explained or include a supplemental file where this information is explained. The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). Any remittance advice related to an EFT must be sent to the provider, no later than the date of the EFT.

The remittance advice shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data.

If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

In accordance with 42 CFR 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: ‘‘I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws.

9.7.7 Claims System Audits

The Contractor shall develop and implement an internal claims audit function that will include at a minimum, the following:

1. Verification that provider contracts are loaded correctly, and
2. Accuracy of payments against provider contract terms.

Audits of provider contract terms must be performed on a regular and periodic basis and consist of a random, statistically significant sampling of all contracts in effect at the time of the audit. The audit sampling methodology must be documented in policy and the Contractor shall review the Contract loading of both large groups and individual practitioners at least once every three (3) - year period in addition to any time a Contract change is initiated during that timeframe. The findings of the audits specified above must be documented and any deficiencies noted in the resulting reports must be met with corrective action.

In addition, in the event of a system change or upgrade, the Contractor shall also be required to initiate an independent audit of the Claim Payment/Health Information System. FSSA will approve the scope of this audit and may include areas such as a verification of eligibility and enrollment information loading, Contract information management (contract loading and auditing), claims processing and encounter submission processes, and will require a copy of the final audit findings.

FSSA shall have the right to perform a random sample audit of all claims and expects the Contractor to fully comply with the requirements of the audit, and provide all requested documentation, including provider claims and encounters submissions.

9.7.8 Recoupments

The Contractor's claims processes, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of fifty thousand dollars ($50,000) per provider or Tax Identification Number within a Contract Year or greater than twelve (12) months after the date of the original payment must be approved by FSSA.

The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. All replaced or voided encounters must reach adjudicated status within one hundred and twenty (120) days of the approval of the recoupment.

In accordance with IC 27-8-5.7-10 the Contractor may not recoup a claim (i.e. request a provider refund or adjust subsequent claims) more than two (2) years after the date of an overpayment, except in cases of fraud.

9.7.9 Claims System Changes

The Contractor shall ensure that changing or making major upgrades to the information systems affecting claims processing, payment or any other major business component, is accompanied by a plan which includes a timeline, milestones, and outlines adequate testing to be completed before implementation. The Contractor shall notify and provide the system change plan to FSSA for review and comment at least ninety (90) calendar days of the projected date of the change.

9.7.10 Claims Reports

The Contractor shall submit claims processing and adjudication data as prescribed by the Reporting Manual. The Contractor shall also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing.

9.8 Encounter Data Submission

The Contractor shall have policies, procedures and mechanisms in place to support the encounter data reporting process described below and in the State fiscal agent's Companion Guides. The Contractor shall strictly adhere to requirements established by the State and to the standards set forth in the State fiscal agent's Companion Guides, as may be amended from time to time, such as the file structure and content definitions (including any content definitions as may further be interpreted or defined by FSSA).

The quality of Contractor's encounter data submissions shall be subject to audit and validation. The Contractor shall fully comply with all such audit and validation activities including, but not limited to, attending meetings, providing background information on encounter data submissions, providing access to systems, records, and personnel that can assist auditors with their work, and timely responding to all information requests from the State or its auditors.

The Contractor technical meetings with FSSA and the Fiscal Agent provides a forum for Contractor technical support staff to participate in the development of the data exchange process and ask questions related to data exchange issues, including encounter data transmission and reporting issues. The Contractor shall report any problems it is experiencing with encounter data submissions and reporting at this monthly meeting and to its designated FSSA Policy Analyst.

9.8.1 Definition and Uses of Encounter Data

The Contractor shall submit an encounter claim to the State fiscal agent or its designee for every service rendered to a member for which the Contractor either paid or denied reimbursement. Encounter data provides reports of individual patient encounters with the Contractor's health care network. These claims contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts and rendering providers' identification numbers and other detailed claims data required for quality improvement monitoring and utilization analysis. The Contractor shall ensure that submitted encounter claims reflect the final adjudication of payment made from the Contractor to the provider. After the initial payment, if changes in provider payment or third-party contributions change the amount paid by the Contractor, the Contractor shall submit an adjustment to the encounter claim displaying the final payment made by the Contractor to the provider, along with any updated data fields relevant to the final provider payment. This includes payments that were changed based on post-payment audit, even if the provider did not resubmit the claim to the Contractor with the updated data fields. For example, if a post-payment audit finds that a different DRG/SOI or billed amount should be used to calculate the payment, those fields should be resubmitted on the adjusted encounter. The State will use the encounter data to make tactical and strategic decisions related to the [MLTSS Program Name] program and to the Contract.

For the purposes of this section "paid amount" is defined as the amount paid to the Provider excluding Third Party Liability, Provider withhold and Provider incentives, and Medical Assistance cost-sharing. For the purposes of this section "allowed amount" is defined as the Provider contracted rate prior to any exclusions or add-ons.

The State shall primarily use the encounter data to make tactical and strategic decisions related to the [MLTSS Program Name] program and to the Contract. The State shall primarily use encounter data to calculate the Contractor's future capitation rates, with alternative data sources utilized as appropriate to meet actuarial and federal standards. Encounter data will also be used to calculate incentive payments to the Contractor, monitor quality and to assess the Contractor's

Contract compliance. See Exhibit 2 for a schedule of liquidated damages that FSSA will assess for non-compliance with encounter data submission requirements.

9.8.2 Reporting Format and Batch Submission Schedule

The Contractor shall submit all encounter claims in an electronic format that adheres to the data specifications in the Companion Guides and any other state or federally mandated electronic claims submission standards or be subject to liquidated damages. As applicable, all required data fields must be included on all encounter claims, including RUG score for nursing facility claims, Diagnosis Related Group (DRG) and Severity of Illness (SOI) for inpatient claims, revenue codes for outpatient claims, procedure codes, diagnosis codes, National Drug Codes (NDCs), units of service, place of service, dates of service, paid dates, billing and rendering provider IDs, billed, allowed, and paid amounts, patient liability (for nursing home claims), copayments/coinsurance/deductible amounts (for both Medicare and commercial coordination of benefits), the claim filing indicator code, and all other fields that may be relevant to payment or patient acuity. The Contractor's encounter claims must include the National Drug Codes (NDCs) when an encounter involves products or services with NDCs, including medical and institutional claims where medications with NDCs are included and billed separately. An indication of claim payment status and an identification of claim transaction type (i.e., original, void/cancel or replacement) is also required, in the form designated by FSSA.

If the Contractor uses a Subcontractor to administer a benefit, for example a dental administrator or Pharmacy Benefit Manager, the "paid amount" is defined as the amount paid to the Provider excluding Third Party Liability, Provider withhold and Provider incentives, and Medical Assistance cost-sharing by the Subcontractor. The Contractor must adhere to repaid amounts for services rendered under sub capitated risk-based arrangements must be estimated using usual and customary payment or for state directed payments the FFS fee schedule and must not include administrative costs or other incentives. See 42 CFR 438.230 on accounting for subcontractor payments to providers.

The Contractor shall submit Home and Community-Based Services encounter data pursuant to the X12 837P national standard. This includes type of service, units of service, and dates of service, sufficient to provide CMS with the required audit trail.

The Contractor shall submit individual-enrollee specific, claim-level data on all post-payment recoveries for all claims on a quarterly basis, in a format determined by the State. This is in addition to the corrected encounter submitted by the Contractor.

The Contractor shall not submit encounters for administrative care coordination.
The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week, or other date and time as specified by the State. FSSA will use an overall average of calendar month submissions to assess compliance with this encounter claim submission requirement. The State shall require the Contractor to submit a corrective action plan and shall assess liquidated damages for failure to comply with the encounter claims submission requirements. See Exhibit 2 for a schedule of liquidated damages FSSA shall assess for non-compliance with this requirement. Only data and information accepted by the data warehouse within six (6) months of the end of the base data year shall be considered for the next year's capitation rate adjustments.

9.8.3 Encounter Claims Quality

The Contractor shall have written policies and procedures to address its submission of encounter claims to the State. These policies shall address the submission of encounter data from any sub capitated providers or subcontractors. At least annually, or on a schedule determined at the

discretion of the State, the Contractor shall submit an encounter claims work plan that addresses the Contractor's strategy for monitoring and improving encounter claims submission.

The Contractor shall comply with the following requirements:

a. Timeliness of Contractor's Encounter Claims Submission: The Contractor shall submit ninety eight percent (98%) of adjudicated claims within fourteen (14) calendar days of adjudication. The Contractor shall submit all encounter claims within fifteen (15) months of the earliest date of service on the claim. The Contractor shall submit claim adjustments – both void/replacement claims – within two (2) years from the date of service.

b. Compliance with Pre-cycle Edits: The State or its designee will assess each encounter claim for compliance with pre-cycle edits. The Contractor must correct and resubmit any encounter claims that do not pass the pre-cycle edits.

c. Accuracy of Encounter Claims Detail: The Contractor shall demonstrate that it implements policies and procedures to ensure that encounter claims submissions are accurate; that is, that all encounter claims detail being submitted accurately represents the services provided and that the claims are accurately adjudicated according to the Contractor's internal standards and all state and federal requirements. FSSA shall have the right to monitor Contractor encounter claims for accuracy against the Contractor's internal criteria and its level of adjudication accuracy. FSSA shall regularly monitor the Contractor's accuracy by reviewing the Contractor's compliance with its internal policies and procedures for ensuring accurate encounter claims submissions and by performing a random sample audit of all claims. FSSA expects the Contractor to fully comply with the requirements of the review and audit and to provide all requested documentation, including provider and encounter claims submissions and medical records. FSSA shall require the Contractor to submit a corrective action plan and will require non-compliance remedies for the Contractor's failure to comply with encounter claims accuracy reporting standards.

d. Completeness of Encounter Claims Data: The Contractor shall have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers, i.e., for every service provided, providers shall submit a corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions, including National Drug Codes as applicable. The Contractor shall also have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided.

The Contractor shall adhere to CMS encounter submission requirements under 42 CFR 438.242. Encounters shall include allowed amounts and paid amounts. Subcontractor administrative costs must be excluded from paid amounts. Enhanced services paid by the Contractor shall not be submitted to the state as an encounter claim.

As part of its annual encounter claims work plan, the Contractor shall demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance. FSSA may require the Contractor to demonstrate, through report or audit, that this monitoring system is in place and that the Contractor is regularly monitoring the completeness of claims and encounter data and ensuring that the Contractor is meeting FSSA's completeness requirements.

FSSA shall require the Contractor to submit a corrective action plan and will require non-compliance remedies for the Contractor's failure to comply with encounter claims completeness reporting standards, as identified in the Encounter Data Quality Validation template.

9.9 Coordination of Benefits and Third Party Liability (TPL)

Prior to payment of claims for covered services for members under this contract, the Contractor shall ensure service providers complete the pursuit and collection of monies from third party payers. Program funding shall be used as a source of payment for covered services only after all other sources of payment have been exhausted and shall be the payor of last resort unless specifically prohibited by applicable State or Federal law. Pursuit of collections will include third party liability insurers and casualty collections such as private health insurance, Medicare, employer sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs. If determined that a potentially liable third party exists, the Contractor must ensure that the provider bills the third party first before sending the claim to the MCE. If the Contractor has paid claims and subsequently discovers the existence of a liable third party it must attempt to recover the money from the liable third party.

The Contractor shall share information regarding its members with other payers as specified by FSSA and in accordance with 42 CFR 438.208(b), which relates to coordination of care. In the process of coordinating care, the Contractor must protect each member’s privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164.

The Contractor shall be responsible for payment of the member's coinsurance, deductibles, co-payments and other cost-sharing expenses required under third party coverage, but the Contractor's total liability shall not exceed what the Contractor would have paid in the absence of TPL, after subtracting the amount paid by the primary payer. A remittance advice shall be created for the provider even if the Contractor liability is zero dollars. The Contractor shall coordinate benefits and payments with the other insurer for services authorized by the Contractor but provided outside the Contractor's plan. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the member or provider of service by the Contractor shall not prevent or unduly delay a member from receiving medically necessary services. The Contractor remains responsible for the costs incurred by the member with respect to care and services which are included in the Contractor's capitation rate, but which are not covered or payable under the other insurer's plan.

The Contractor must have a signed Coordination of Benefits Agreement (COBA) with CMS and participate in the automated crossover claim process administered by Medicare.

In accordance with IC 12-15-8 and 405 IAC 1-1-15, FSSA has a lien upon any money payable by any third party who is or may be liable for the medical expenses of a Medicaid recipient when Medicaid provides medical assistance. The Contractor may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

9.9.1 Collection and Reporting

The Contractor will be responsible for identifying, collecting and reporting third party liability coverage and collection information to the State. As third-party liability information is a component of capitation rate development, the Contractor shall maintain records regarding third party liability collections and report these collections to OMPP in a manner prescribed by the Reporting Manual. The Contractor will retain all TPL collections from any insurer or responsible party made on behalf of its members.

9.9.2 Cost Avoidance

The Contractor’s TPL responsibilities include cost avoidance. When the Contractor is aware of other insurance coverage prior to paying for a health care service for a member, it should avoid payment by rejecting a provider's claim and direct that the provider first submits the claim to the appropriate third party.

When the Contractor has identified members who have health insurance, the Contractor shall validate the insurance prior to using that data for cost avoidance. If insurance coverage information is not available, or if one of the exceptions to the cost avoidance rule discussed in this section applies, then the Contractor shall make the payment and make a claim against the third party, if it is determined that the third party is or may be liable. The Contractor shall ensure that its cost avoidance efforts do not prevent a member from receiving medically necessary services in a timely manner.

9.9.3 Retroactive Medicare Coverage

Program members may become retroactively Medicare eligible. When this occurs, the Contractor shall recover medical expenses payable by Medicare for the months of retroactive Medicare eligibility. The State will recoup the capitation rate paid for months with retroactive Medicare eligibility and pay a reduced dual-eligible capitation rate, as applicable.

9.9.4 Cost Avoidance Exceptions

In accordance with 42 CFR 433.139(c), if the probable existence of third party liability cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the Contractor must first pay the provider and then pursue reimbursement from the potentially liable third party within sixty (60) days after the end of the month in which payment is made.

Retroactive Recoveries Involving Commercial Insurance Payor Source: For a period of two years from the date of service, the Contractor shall engage in retroactive third party recovery efforts for claims paid to determine if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, the Contractor shall seek recovery from the commercial insurance. The Contractor is prohibited from recouping related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way, unless the provider was paid in full from both the Contractor and the commercial insurance. Encounters shall be adjusted as a result of retroactive recoveries.

9.9.5 TPL Special Circumstances

Timely Filing: The Contractor shall not deny a claim for timeliness if the untimely claim submission results from a provider's efforts to determine the extent of a third party liability.

The Contractor shall waive timely filing in cases where a retroactive coverage change or error has resulted in another MCE, Insurer, or Fee for Service recouping or recovering a claim. The Contractor shall permit the provider to submit a claim for payment within ninety (90) days of claim's recovery or recoupment notice from the previous payer.

Medicare regulations 42 C.F.R. §424.44(b) allows for exceptions to the one (1) calendar year time limit for filing Medicare claims. Retroactive Medicare entitlement involving State Medicaid Agencies, where a State Medicaid Agency recoups payment from a provider or supplier six (6) months or more after the date the service was furnished to a dually eligible beneficiary, is an allowed exemption. Refer to Chapter 1, subsection 70.7 of the Medicare Claims Processing manual for qualifying exceptions and associated billing instructions.

OMPP will be responsible for estate recovery activities.

9.10 Electronic Visit Verification (EVV) Requirements

The Contractor shall work with FSSA, its fiscal agent, and FSSA's electronic visit verification (EVV) partner to implement an EVV solution which meets the requirements under section 12006 (a) of the 21st

Century Cures Act. The Contractor must utilize the State Sponsored-EVV Solution's aggregator of EVV records when verifying the presence of EVV records for all impacted personal care and home health services during claims adjudication. The Contractor may only utilize EVV for claims payments on services determined by FSSA to require EVV and only enforce claims denials for missing or inaccurate EVV records based upon the timeframe established by FSSA.

10.0 Performance Reporting and Incentives

FSSA places great emphasis on the delivery of quality health care to members. Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered in [MLTSS Program Name]. The State will require and use various deliverables, performance targets, industry standards, national benchmarks and program-specific standards in monitoring the Contractor's performance and Outcomes, for both the Contractor's Medicaid and their Dual Eligible Special Needs Program (DSNP). During the term of the contract, the State intends to publish key performance metrics that may include but not be limited to, claims performance, prior authorization data, quality performance metrics, network adequacy and/or utilization reports. Public reporting will allow FSSA to compare and monitor plan performance as well as provide members, providers and stakeholders information to compare health plan performance.

In an effort to monitor health plan performance and member, informal caregiver, and provider satisfaction, FSSA reserves the right to conduct and publicly share survey results and other data elements collected for analysis during the term of the contract.

Additionally, beginning in year two (2) of the Contract, the State may utilize performance outcomes as a factor for auto-assignments and enrollment materials developed to facilitate member choice of an MCE.

The Contractor must comply with all reporting requirements and must submit the requested data. The State reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors.

The Contractor must have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to FSSA is accurate. In accordance with 42 CFR 438.604 and 42 CFR 438.606 all data must be certified by the Contractor's Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to one of these employees. The certification must attest, based on best knowledge, information and belief to the accuracy, completeness and truthfulness of the data and documents submitted to the State. This certification must be submitted concurrently with the certified data. For reference, the current Reporting Manual is provided in the Bidders' Library.

FSSA reserves the right to audit the Contractor's self-reported data and change reporting requirements at any time with reasonable notice. FSSA may require corrective action as outlined in Contract Exhibit 2 Contract Compliance and Pay for Outcomes for Contractor non-compliance with these and other subsequent reporting requirements and performance standards. FSSA may change the frequency of reports and may require additional reports at any time. In these situations, FSSA shall provide at least thirty (30) calendar days' notice to the Contractor before changing reporting requirements. FSSA may request ad hoc reports at any time.

The Reporting Manual will detail reporting requirements and the full list of required reports and reporting methods. The Contractor shall comply with all State instructions regarding submission requirements, including but not limited to, formatting, timeliness and data uploading instructions.

FSSA may schedule meetings or conference calls with the Contractor upon receiving the performance data. When FSSA identifies potential performance issues, the Contractor must formally respond in writing to these issues within five (5) business days of the receipt of the feedback meeting or conference call. If the Contractor fails to provide a formal, written response to the feedback or fails to respond within five (5)

business days, FSSA may consider the vendor(s) noncompliant in its performance reporting and may implement corrective actions.

10.1 Financial Reports

Financial Reports assist FSSA in monitoring the Contractor's financial trends to assess its stability and continued ability to offer health care services to its members. If the Contractor does not meet the financial reporting requirements, FSSA will notify the Contractor of the noncompliance and designate a period of time, not less than ten (10) calendar days, during which the Contractor must provide a written response to the notification. Contractors must meet IDOI licensure and financial requirements. Examples of Financial Reports to be submitted by the Contractor, in accordance with the terms of the Reporting Manual, include but are not limited to:

- IDOI Filing;
- Physician Incentive Plan Disclosure;
- Encounter Data Quality Validation template;
- Insurance Premium Notice;
- Capitation Reconciliation Report;
- Vendor Contact Sheet; and
- Key Staff and Other Staffing

On an annual basis, the Contractor must submit program specific audited financial reports, separate for each managed care program (i.e., HIP, Hoosier Healthwise, Hoosier Care Connect, and [MLTSS Program Name] as applicable). The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. Audits should be performed for calendar years using data on a services incurred basis with six (6) months of claims run-out. The audit must detail the medical expense payments reported net of subcontracted administrative expenses and categorize all quality improvement spending into the allowed five categories. The audit shall review if quality improvement spending passes the requirements under 45 CFR 158.150b. Audits should be performed for calendar years using data on a services-incurred basis with six months of claims run-out.

10.2 Member Service Reports

Member Service Reports identify the methods the Contractor uses to communicate to members about preventive health care and program services and monitor member satisfaction.

FSSA reserves the right to require more frequent Member Service reporting at the beginning of the Contract and as necessary to ensure satisfactory levels of member service.

10.3 Network Development Reports

Network Development Reports assist FSSA in monitoring the Contractor's network composition by specialty and geo-access ratios in order to assess member access and network capacity. The Contractor shall identify current enrollment, gaps in network services and the corrective actions that the Contractor is taking to resolve any potential problems relating to network access and capacity.

FSSA will require more frequent Network Geographic Access Assessment reporting at the beginning of the Contract and during implementation of program changes as necessary to ensure satisfactory network access, until the Contractor demonstrates that the network access standards have been met.

10.4 Provider Service Reports

Provider Service Reports assist FSSA in monitoring the methods the Contractor uses to communicate to providers about clinical, technical and quality management and improvement issues relating to the

program. FSSA reserves the right to require more frequent provider service reporting at the beginning of the contract to ensure satisfactory levels of provider service.

10.5 Quality Management Reports

Quality Management Reports document the methods and processes the Contractor uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports assist FSSA in monitoring the Contractor's quality management and improvement activities.

10.6 Utilization and Authorization Reports

Utilization Reports assist FSSA in monitoring the Contractor's utilization trends, performance and progress towards performance targets. The Contractor will monitor utilization by subpopulation when appropriate and as directed by FSSA.

The State reserves the right to require the Contractor to submit regular prior authorization detail information on every prior authorization request received and processed in an electronic State specified format.

10.7 Claims Reports

These reports assist FSSA in monitoring the Contractor's claims processing activities to ensure appropriate member access to services and payments to providers. The Contractor shall submit claims processing and adjudication data. The Contractor shall also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing.

10.8 Care Coordination and Service Coordination Reporting

Care Coordination and Service Coordination Reports are necessary to monitor the critical collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet members' individual health needs through communication and available resources to promote quality and cost-effective outcomes. Care Coordination and Service Coordination reports will include metrics and performance data on Service Plan Timeline Requirements referenced in Section 4.10.5.

10.9 Health Outcomes and Clinical Reporting

Health Outcomes and Clinical Reports assist FSSA in monitoring the health status of [MLTSS Program Name] enrollees and to identify the effectiveness of Contractor interventions.

10.10 CMS Reporting

The Contractor shall be required to submit data requested by the Centers for Medicare and Medicaid Services (CMS), including but not limited to all required MCE reporting obligations described in the CMS Special Terms and Conditions (STCs) for the State's waiver. For example, in addition to the specific reports described in the STCs, CMS often requests additional data and reports in advance of FSSA's monthly conference calls with CMS. In preparation for these calls, FSSA will require the Contractor to submit the data requested by CMS. The Contractor shall submit this data in the timeframe specified by FSSA.

10.11 Other Reporting

OMPP shall have the right to require additional reports to address program-related issues that are not anticipated at the Contract start date but are determined by FSSA to be necessary for program monitoring.

11.0 Failure to Perform/Non-compliance Remedies

11.1 Non-compliance Remedies

It is the State's primary goal to ensure the Contractor is delivering quality care to members. To meet this goal, the State monitors quality and performance standards and holds the Contractor accountable for complying with Contract terms at all times. FSSA will work collaboratively with the Contractor to maintain and improve programs, and not to impair health plan stability.

In the event the Contractor fails to meet performance requirements or reporting standards set forth in this Scope of Work, Exhibit 2, or the Contractor Reporting Manual, the State will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies set forth in Exhibit 2. The State will provide written notice of non-compliance to the Contractor within sixty (60) calendar days of the State's discovery of such non-compliance.

Notwithstanding the foregoing, any failure or delay on the part of the State in providing written notice or otherwise exercising any right, power or remedy under the Contract will not operate as a waiver of such right, power or remedy, and no single or partial exercise of any such right, power, or remedy will preclude any other or further exercise of such right, power or remedy. Except as specifically set forth herein, the rights and remedies available pursuant to this Contract are cumulative in nature and not alternative. For example, if FSSA elects not to exercise a corrective action clause contained anywhere in the Contract in a particular instance, this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the Contract, may be retroactively assessed.

11.2 Evidence of Financial Responsibility

The State reserves the right to require a performance bond of standard commercial scope issued by a surety company registered with the IDOI or other evidence of financial responsibility to guarantee performance by the Contractor of its obligations under the Contract.

The State reserves the right to implement financial responsibility requirements if enrollment levels indicate the need to do so. If these requirements are implemented and default by the Contractor occurs, the State shall, in addition to any other remedies it may have under the Contract, obtain payment under the performance bond or other arrangement for the purposes of the following:

1. Reimbursing the State for any expenses incurred by reason of a breach of the Contractor's obligations under the Contract, including, but not limited to, expenses incurred after termination of the Contract for reasons other than the convenience of the State.

2. Reimbursing the State for costs incurred in procuring replacement services.

12.0 Termination Provisions

12.1 Contract Terminations

FSSA reserves the right to terminate this Contract in whole or in part, and transition members to a different Contractor, due to the failure of the Contractor to comply with any term or condition of the Contract, or failure to take corrective action as required by FSSA to comply with the terms of the Contract.

The Contract between the State and the Contractor may be terminated as follows:

1. By mutual written agreement of the State and Contractor;
2. By the Contractor, subject to the remedies listed in the Contract;

3. By the State, in whole or in part, whenever the State determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities including, but not limited to, circumstances which present risk to member health or safety, and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.70 or has failed to meet the applicable requirements of sections 42 CFR 438.708(a), 42 CFR 438.708(b), sections 1903(m), 1905(t), and 1932 of the Social Security Act and is unable to cure such failure within thirty (30) calendar days after receipt of a notice specifying those conditions;
4. By the State, in whole or in part, whenever, for any reason, the State determines that such termination is in the best interest of the State, with at least thirty (30) calendar days' prior notice to the Contractor. Such termination is referred to herein as "Termination for Convenience;"
5. By the State, in whole or in part, whenever funding from state, federal or other sources are withdrawn, reduced or limited, with sufficient prior notice to the Contractor; or
6. By the State, in whole or in part, whenever the State determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of Contractor responsibilities.

The State will provide the Contractor with a pre-termination hearing prior to contract termination in accordance with 42 CFR 438.710(b).

12.1.1 Termination by the State for Contractor Default

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor or a subcontractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable or unwilling to cure such failure within thirty (30) calendar days, or such other reasonable period of time as specified in writing by the State, taking into consideration the gravity and nature of the default. Such termination is referred to herein as "Termination for Default."

Upon determination by the State that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities, the Contractor must be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable or unwilling to cure the failure within the specified time period, the State may notify the Contractor that the Contract, in full or in part, has been terminated for default.

If, after providing notice of Termination for Default, it is determined by either the State or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Contractor or any of its subcontractors, the notice of termination will not be considered a Termination for Default, but must be deemed to have been issued as a Termination for Convenience, and the rights and obligations of the parties must be governed accordingly.

In the event of Termination for Default, in full or in part, as provided under this clause, the State may procure, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the State for costs incurred to procure such similar supplies or services as are needed to continue operations.

In the event of a Termination for Default prior to the start of operations, any claim the Contractor may assert must be governed by the procedures defined in the Contract. In the event of a Termination for Default during ongoing operations, the Contractor will be paid for any outstanding capitation payments due, less any assessed damages. The rights and remedies of the State

provided in this Section are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

12.1.2 Termination for Financial Instability

The State may terminate the Contract upon the occurrence of any of the following events:

1. The Contractor becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under the Contract;
2. The Contractor ceases to conduct business in normal course;
3. The Contractor makes a general assignment for the benefit of creditors; or
4. The Contractor suffers or permits the appointment of a receiver for its business or assets.

The State may, at its option, immediately terminate the Contract effective at the close of business on the date specified. In the event the State elects to terminate the Contract under this provision, the Contractor must be notified in writing, by either certified or registered mail, specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor must immediately inform the Contract Administrator as specified in the Contract between the State and the Contractor. The Contractor must ensure that all tasks related to the subcontract are performed in accordance with the terms of the Contract.

12.1.3 Termination for Failure to Disclose Records

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor has failed to make available to any authorized representative of the State, any administrative, financial or medical records relating to the delivery of services for which State program dollars have been expended.

In the event that the State terminates the Contract pursuant to this provision, the Contractor must be notified in writing, either by certified or registered mail, either sixty (60) calendar days prior to or such other reasonable period of time prior to the effective date, of the basis and extent of the termination. Termination must be effective as of the close of business on the date specified in the notice.

12.1.4 Termination by the Contractor

The Contractor must give advance written notice of termination, or intent not to renew, to the State a minimum of one hundred eighty (180) calendar days prior to termination or expiration. The effective date of the termination must be no earlier than the last day of the month in which the one hundred and eightieth (180th) day falls. Termination of the Contract by the Contractor is subject to damages listed in Section 12.4.

12.2 Termination Procedures

If the Contractor is providing services under more than one contract with Indiana Medicaid, the State may deem unsatisfactory performance under one contract to be cause for requiring the Contractor to provide assurance of performance under any and all other contracts. In such situations, the State reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received.

When termination is anticipated, FSSA will deliver to the Contractor a Notice of Termination by certified or registered mail specifying the nature of the termination and the date upon which such termination

becomes effective. Within ten (10) calendar days of receipt of the Notice of Termination, the Contractor must submit a written plan of termination ("Transition Plan") for FSSA's approval.

The Transition Plan shall, at minimum, address the following:

1. Stopping work under the Contract on the date and to the extent specified in the Notice of Termination.
2. Notifying all of the Contractor's members regarding the date of termination and the process by which members will continue to receive medical care. FSSA must approve all member notification materials in advance of distribution.
3. Terminating all orders and subcontracts, to the extent that they relate to the performance of work terminated by the Notice of Termination.
4. Assigning activities to the State, its designee or successor contractor, in the manner and to the extent that they relate to the performance of work terminated by the Notice of Termination.
5. Assigning to the State, its designee or successor contractor, in the manner and to the extent directed, all of the rights, titles and interests of the Contractor under the orders or subcontracts so terminated.
6. With the approval of the State, settling outstanding liabilities and all claims arising out of such termination of orders and subcontracts.
7. Within ten (10) business days from the effective date of the termination, transferring title to the State of Indiana (to the extent that title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information and documentation, in any form that relates to the work terminated by the Notice of Termination.
8. Taking such action as may be necessary, or as the State may direct, for the protection and preservation of the property related to the Contract that is in the possession of the Contractor and in which the State has or may acquire an interest.
9. Providing for all the Contractor's responsibilities set forth in Section 12.3.

The requirements listed above are illustrative only and do not limit or restrict the State's ability to require the Contractor to address additional issues in its Transition Plan. The State shall withhold the Contractor's final capitation payment until the Contractor has (a) received FSSA approval of its Transition Plan, and (b) completed the activities set forth in its Transition Plan, as well as any additional activities requested by FSSA, to the satisfaction of FSSA, in its sole discretion.

12.3 Contractor Responsibilities upon Termination or Expiration of the Contract

Termination or expiration of the Contract does not discharge the obligations of the Contractor with respect to services or items furnished prior to termination or expiration of the Contract, including retention of records and verification of overpayments or underpayments. Termination or expiration of the Contract does not discharge the State's payment obligations to the Contractor or the Contractor's payment obligations to its subcontractors and providers. Upon termination or expiration of the Contract, the Contractor must:

1. Assist the State in taking the necessary steps to ensure a smooth transition of members and services.
2. Provide a written Transition Plan for the State's approval, in accordance with Section 12.2. In the event of Contract termination, the Transition Plan shall be due within ten (10) calendar days of receiving Notice of Termination from the State. In the event of Contract expiration, the Transition Plan shall be due at least one hundred eighty (180) calendar days prior to expiration of the

Contract. The Contractor will revise and resubmit the Transition Plan to the State on a regular basis, the frequency of which will be determined by the State.

3. Appoint a transition coordinator and a liaison for post-transition concerns.
4. Provide for sufficient claims payment staff, member services staff, and provider services staff to ensure a successful transition and payment of all outstanding obligations.
5. Provide all information requested by the State in the format and within the timeframes set forth by the State, which shall be no later than thirty (30) calendar days of the request.
6. Assist the State and/or its subcontractors in FQHC/RHC settlement process for settlement periods prior to the day of termination or expiration of the Contract. Requested assistance may include but is not limited to data support for questions regarding FQHC/RHC claims data and reports and the submission of claims data files to the State and/or its vendors.
7. Be financially responsible for all claims with dates of service through the day of termination or expiration of the Contract, including those submitted within established time limits after the day of termination or expiration of the Contract.
8. Be responsible for submitting all required reports as required in the Reporting Manual unless waived by FSSA.
9. Be responsible for cooperating with the State on any reconciliation processes that occur after the termination or expiration of the Contract.
10. Be responsible for submitting complete and accurate encounter data to the State for all claims incurred prior to the contract expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after termination or expiration of the Contract.
11. Be responsible for submitting all reports necessary to facilitate the collection of pharmacy rebates and assisting in the resolution of all drug rebate disputes with the manufacturer for all claims incurred prior to the contract expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after the termination or expiration of the Contract.
12. Be responsible for submitting all performance data with a due date following the termination or expiration of the Contract but covering a reporting period prior to termination or expiration of the Contract, including but not limited to CAHPS, HEDIS, Reimbursement for FQHC and RHC Services and the Capitation Rate Calculation Sheet.
13. Be responsible for resolving member grievances and appeals with respect to claims with dates of service prior to or on the day of contract termination or expiration, including grievances and appeals filed on or after the day of Contract termination or expiration but with dates of service prior to the day of Contract termination or expiration.
14. Be financially responsible for inpatient services for patients hospitalized on or before the day of Contract termination or expiration through the date of discharge, including the DRG payment and any outlier payments.
15. Be financially responsible for services rendered through the day of termination or expiration of the Contract, for which payment is denied by the Contractor and subsequently approved upon appeal by the provider.
16. Be financially responsible for member appeals of adverse decisions rendered by the Contractor concerning treatment of services requested prior to termination or expiration of the Contract which are subsequently upheld on behalf of the member after an appeal proceeding or after a FSSA Fair Hearing.
17. Arrange for the orderly transfer of patient care and patient records to those providers who will assume care for the member. For those members in a course of treatment for which a change of providers could be harmful, the Contractor must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged. The Contractor shall transfer all applicable clinical information on file, including but not limited to approved and outstanding prior

authorization requests and a list of members in case or care management, to the State and/or the successor MCE at least fourteen (14) business days prior to the day of termination or expiration of the Contract. A final file shall be provided within five (5) business days of the termination or expiration of the Contract.

18. Coordinate the continuation of care for members.
19. Notify all members about the Contract termination and the process by which members will continue to receive medical care, at least sixty (60) calendar days in advance of the effective day of termination or expiration of the Contract. The Contractor will be responsible for all expenses associated with member notification. FSSA must approve all member notification materials in advance of distribution.
20. Notify all providers about the Contract termination and the process by which members will continue to receive medical care, at least sixty (60) calendar days in advance of the effective day of termination or expiration of the Contract. The Contractor will be responsible for all expenses associated with provider notification. FSSA must approve all provider notification materials in advance of distribution.
21. Report any capitation or other overpayments made by the State to the Contractor within thirty (30) calendar days of discovery and cooperate with investigations by the State or its subcontractors into possible overpayments made during the contract term. The Contractor shall return any capitation or other overpayments, including those discovered after contract expiration, to the State within fourteen (14) calendar days of reporting the overpayment to the State.
22. Be responsible to submit the HEDIS Auditor Report listed in Section 7.1.12, in accordance with the applicable due date, and to participate in the External Quality Review, as required by 42 CFR 438, Subpart E, for the final year of the Contract.
23. Allow the State, CMS, the OIG, the Comptroller General, and their designees to audit records or documents of the Contractor and their subcontractors for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.
24. Retain, preserve and make available records, within the timeframes required by federal law, including but not limited to 45 CFR 164.530(j)(2) and 42 CFR 438.3(u).
25. Comply with any additional items the State required the Contractor to address in its Transition Plan.
    a. The State reserves the right to withhold some or all retroactive capitation adjustment payments due and owing to the Contractor in the event the Contractor fails to comply with the responsibilities set forth in this section, including its responsibilities related to data submission and support.
    b. In addition, the State reserves the right to extend the term of the Contract on a month-to-month basis to assist in any member transitions to a new Contractor. The State may discontinue enrollment of new members with the Contractor three months prior to the contract termination date or as otherwise determined by the State. The Contractor shall make provisions for continuing all management and administrative services until the transition of members is completed and all other requirements of this Contract are satisfied.

12.4 Damages

The Contractor acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State, which may not be adequately compensable in damages. The Contractor acknowledges that the State has incurred substantial expenses in connection with the preparation and entry into the Contract, including expenses relating to training staff, data collection and processing, actuarial determination of capitation rates, and ongoing changes to the State's and its fiscal agent's management IT systems.

The Contractor further acknowledges and agrees that in the event the Contract is terminated prior to the end of the initial term or any renewal term, due to the actions of the Contractor or due to the Contractor's failure to fully comply with the terms and conditions of the Contract, the State will incur substantial additional expense in processing the disenrollment of all members and the related MMIS changes, in effecting staffing changes, in procuring alternative health care arrangements for members, and in other areas unknown to the State at this time. The Contractor accordingly agrees that the State may, in such event, seek and obtain actual damages.

The remedies available to the State under this Agreement include but are not limited to:

1. Obtaining payment under the performance bond or other arrangement set forth in Section 11.2.
2. Assessing actual damages measured by the cost to the State to transition members to other providers and/or another Contractor. This includes, but is not limited to, payments the State may make to other contractors to perform work related to the transition; and
3. Assessing actual damages measured by the loss of anticipated savings to the State the enrollment in the [MLTSS Program Name] was expected to realize.

Payment under the performance bond or other arrangement established under 11.2 is due within ten (10) calendar days of the date of termination. Payment of liquidated damages is due within thirty (30) calendar days from the date of termination. Payment of actual damages is due within ten (10) calendar days of the Contractor's receipt of the State's demand for payment.

12.5 Assignment of Terminating Contractor's Membership and Responsibilities

If the Contract is terminated for any reason, the State may assign the Contractor's membership and responsibilities to one (1) or more other MCEs who also provide services to the [MLTSS Program Name] population, subject to consent by the MCE that would gain the member enrollment.

In the event that FSSA assigns members or responsibility to another MCE, during the final quarter of the Contract, the Contractor will work cooperatively with, and supply program information to, any successor MCEs. Both the program information and the working relationship among the Contractor and successor MCEs will be defined by the State.

12.6 Refunds of Advanced Payments

The Contractor must, within thirty (30) calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the Contract.

12.7 Termination Claims

If the Contract is terminated under this Section 12, the Contractor must be entitled to be paid a prorated capitation amount, determined by the State based on available information, for the month in which Notice of Termination was received for the service days prior to the effective date of termination. The Contractor will have the right of appeal, as stated under the subsection on Disputes in the Contract, of any such determination. The Contractor will not be entitled to payment of any services performed after the effective date of termination.