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AMENDMENT #1

CONTRACT #00000000000000000000082035

This is an Amendment to the Contract (the "Contract") entered into by and between the Indiana Family and Social Services Administration (FSSA) (the "State") and Arcadian Health Plan, Inc. d.b.a. Humana Healthy Horizons in Indiana (the "Contractor"), approved by the last State signatory on May 23, 2024.

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

The Contract for providing risk-based managed care services to Medicaid beneficiaries enrolled in the State of Indiana's PathWays for Aging program is hereby amended to update Exhibits 1, 2, 3, 5, and 6. Unless otherwise noted, and subject to specific provisions within each Exhibit, this amendment shall be effective **July 1, 2025**.

Exhibit 1, which outlines the Scope of Work – Indiana PathWays for Aging, is hereby superseded and replaced by **Exhibit 1.A**, which is attached hereto and incorporated herein.

Exhibit 2, which outlines the Contract Compliance and Pay for Outcomes, is hereby superseded and replaced by **Exhibit 2.A**, which is attached hereto and incorporated herein.

Exhibit 3, which outlines the Program Description and Covered Benefits, is hereby superseded and replaced by **Exhibit 3.A**, which is attached hereto and incorporated herein.

Exhibit 5, which outlines the Contract Definitions, is hereby superseded and replaced by **Exhibit 5.A**, which is attached hereto and incorporated herein.

Exhibit 6, which outlines the Indiana PathWays for Aging Capitation Rates, is hereby superseded and replaced by **Exhibit 6.A**, which is attached hereto and incorporated herein.

Funding in the amount of **$1,657,232,247.04** is being removed from the total contract amount. Total remuneration for this contract shall not exceed **$7,984,369,222.08.**

Clause 18. Employment Eligibility Verification of the original Contract is deleted replaced in its entirety by the following:

18. Employment Eligibility Verification

As a condition precedent to entering this Contract and as required by IC § 22-5-1.7 and Executive Order 25-29, the Contractor swears or affirms under the penalties of perjury that the Contractor has not knowingly employed and will not knowingly employ an unauthorized alien. The Contractor further agrees that:

A. The Contractor has enrolled in and verified the work eligibility status of all his/her/its employees through the E-Verify program as defined in IC § 22-5-1.7-3. The Contractor is not required to participate should the E-Verify program cease to exist. Additionally, the Contractor is not required to participate if the Contractor is self-employed and does not employ any employees.

B. The Contractor has not knowingly employed or contracted with, and shall not knowingly employ or contract with, an unauthorized alien. The Contractor has not retained, and shall not retain, an employee, and has not contracted and shall not contract with a person, that the Contractor subsequently learned or learns is an unauthorized alien.

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C. The Contractor has required and shall require his/her/its subcontractors, who perform work under this Contract, to certify to the Contractor that the subcontractor does not knowingly employ or contract with an unauthorized alien and that the subcontractor has enrolled and is participating in the E-Verify program. The Contractor agrees to maintain this certification throughout the duration of the term of a contract with a subcontractor and to provide any and all such certifications to the State promptly upon request.

The State may terminate this agreement for default if the Contractor fails to cure a breach of this provision no later than thirty (30) days after being notified by the State.

The Contractor's Division of Supplier Diversity ("DSD") ongoing obligations remain unchanged, and are as follows:

A. **Clause 26. Indiana Veteran Owned Small Business Enterprise Compliance** remains unchanged with a 0% change in overall commitment obligations. Therefore, Clause 26 remains as follows:

Award of this Contract was based, in part, on the Indiana Veteran Owned Small Business Enterprise ("IVOSB") participation plan, as detailed in the IVOSB Subcontractor Commitment Form, commonly referred to as "Attachment A-1" in the procurement documentation and incorporated by reference herein. Therefore, any changes to this information during the Contract term must be approved by IDOA's Division of Supplier Diversity and may require an amendment. It is the State's expectation that the Contractor will meet the subcontractor commitments during the Contract term. The following certified IVOSB subcontractor(s) will be participating in this Contract:

IVOSB #	PHONE	COMPANY NAME	SCOPE OF PRODUCTS and/or SERVICES	UTILIZATION DATE	PERCENT
0000015988	(317) 488-7722	Professional Management Enterprises	Provide staff augmentation services and staffing and management services for the Behavioral Health and Mental Health Crisis Line.	7/1/2024-6/30/2028	2.21%
0000054974	(317) 719-3895	Summit Managed Solutions LLC	Provide business and corporate management consultation services and project management advisory services for Indiana-specific housing initiatives, including supporting Humana's Innovation Laboratory.	7/1/2024-6/30/2028	1.24%

A copy of each subcontractor agreement must be submitted to the Division of Supplier Diversity within thirty (30) days of the effective date of this Contract. The subcontractor agreements may be uploaded into Pay Audit (Indiana's subcontractor payment auditing system), emailed to IndianaVeteransPreference@idoa.IN.gov, or mailed to IDOA, 402 W. Washington Street, Room W-462, Indianapolis, IN 46204. Failure to provide a copy of any subcontractor agreement may be deemed a violation of the rules governing IVOSB procurement and may result in sanctions allowable under 25 IAC 9-5-2. Requests for changes must be submitted to IndianaVeteransPreference@idoa.IN.gov for review and approval before changing the participation plan submitted in connection with this Contract.

The Contractor shall report payments made to certified IVOSB subcontractors under this Contract on a monthly basis using Pay Audit. The Contractor shall notify subcontractors that they must confirm payments received from the Contractor in Pay Audit. The Pay Audit system can be accessed on the IDOA webpage at: www.in.gov/idoa/mwbe/payaudit.htm. The Contractor may

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also be required to report IVOSB certified subcontractor payments directly to the Division of Supplier Diversity, as reasonably requested and in the format required by the Division of Supplier Diversity.

The Contractor's failure to comply with the provisions in this clause may be considered a material breach of the Contract.

B. **Clause 32. Minority and Women's Business Enterprises Compliance** remains unchanged with a 0% change in overall commitment obligations. Therefore Clause 32 remains as follows:

Award of this Contract was based, in part, on the Minority and/or Women's Business Enterprise ("MBE" and/or "WBE") participation plan as detailed in the Minority and Women's Business Enterprises Subcontractor Commitment Form, commonly referred to as "Attachment A" in the procurement documentation and incorporated by reference herein. Therefore, any changes to this information during the Contract term must be approved by the Division of Supplier Diversity and may require an amendment. It is the State's expectation that the Contractor will meet the subcontractor commitments during the Contract term.

The following Division of Supplier Diversity certified MBE and/or WBE subcontractors will be participating in this Contract:

MBE/WBE #	PHONE	COMPANY NAME	SCOPE OF PRODUCTS and/or SERVICES	UTILIZATION DATE	PERCENT
0000001837	(317) 631-6400	Borshoff, Inc.	Provide brand marketing and advertisement, including Instructional materials, public relations and professional communications services and advertising.	7/1/2024 – 6/30/2028	1.29%
WBE	(770) 315 - 2328	CulturaLink, Inc.	Provide in person language interpretation services, for Burmese, Spanish, American Sign Language and other languages, as needed. The company will also provide business and corporate management consultation services, including services to hospitals for language and cultural competency purposes.	7/1/2024 – 6/30/2028	1.96%
0000011579	(317) 283-8300	Engaging Solutions, LLC	Provide community outreach, educational support services, project and events management, strategic planning and consultation services, engagement services, training and health equity and program assessments.	7/1/2024 – 6/30/2028	3.74%
0000002385	(317) - 218-0650	RepuCare	Provide staffing and recruitment services to support the needs of the MLTSS program.	7/1/2024 – 6/30/2028	0.60%
0000027711	(317) 845-5489	Sahasra Technologies Corp, dba STLogics	Provide information technology and business intelligence consulting services and data analytics. The company will work with Humana to address workforce development challenges and assess program	7/1/2024 – 6/30/2028	3.67%

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			needs and deficiencies. In addition, STLogics will help to address caregiver and health equity issues and provide solutions for workforce shortages.		
0000008092	(765) 749-3791	LCP Transportation	Provide Non-Emergency Transportation (NEMT) services as required by the RFP. In addition, enhanced NEMT services will be offered to Humana members, expanding the basic NEMT benefit to include travel services to other destinations critical to members overall health and to directly address identified gaps.	7/1/2024 – 6/30/2028	7.93%
0000002331	(317) 926-4011	Indiana Minority Health Coalition	Provide disease prevention and control services. They will be responsible for targeted community outreach programs and project management, including providing consulting services and expertise in the health and wellbeing of minority populations in Indiana. Humana members will also be engaged in IMHC Promotoras program.	7/1/2024 – 6/30/2028	0.60%
0000001929	(317) 802 - 1962	Fineline Printing	Responsible for delivering printed materials and fulfillment services and promotional healthcare products	7/1/2024 – 6/30/2028	0.60%
0000043103	(317) 875-0400	Stevenson Legal Group, LLC	Responsible for providing legal services to Humana members.	7/1/2024 – 6/30/2028	0.13%

A copy of each subcontractor agreement must be submitted to the Division of Supplier Diversity within thirty (30) days of the effective date of this Contract. The subcontractor agreements may be uploaded into Pay Audit (Indiana's subcontractor payment auditing system), emailed to MWBECompliance@idoa.IN.gov, or mailed to the Division of Supplier Diversity, 402 W. Washington Street, Room W-462, Indianapolis IN 46204. Failure to provide a copy of any subcontractor agreement may be deemed a violation of the rules governing MBE/WBE procurement and may result in sanctions allowable under 25 IAC 5-7-8. Requests for changes must be submitted to MWBECompliance@idoa.IN.gov for review and approval before changing the participation plan submitted in connection with this Contract.

The Contractor shall report payments made to Division of Supplier Diversity certified subcontractors under this Contract on a monthly basis using Pay Audit. The Contractor shall notify subcontractors that they must confirm payments received from the Contractor in Pay Audit. The Pay Audit system can be accessed on the IDOA webpage at: www.in.gov/idoa/mwbe/payaudit.htm. The Contractor may also be required to report Division of Supplier Diversity certified subcontractor payments directly to the Division, as reasonably requested and in the format required by the Division of Supplier Diversity.

The Contractor's failure to comply with the provisions in this clause may be considered a material breach of the Contract.

Additionally, Clause 34 “Notice to Parties” is hereby deleted and the following substituted therefore:

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34. Notice to Parties.

Whenever any notice, statement or other communication is required under this Contract, it will be sent by E-mail or first class U.S. mail service to the following addresses, unless otherwise specifically advised.

A. Notices to the State shall be sent to:

Mitchell Roob, Secretary of the Family and Social Services Administration and Director of the Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration,
Office of Medicaid Policy and Planning
402 W. Washington Street, Room W461
Indianapolis, IN 46204
Email: mitch.roob@fssa.IN.gov

B. Notices to the Contractor shall be sent to:

John Barger, Medicaid Plan President
Arcadian Health Plan
201 North Illinois Street, Suite 1200
Indianapolis, IN 46204
Email: jbarger3@humana.com

As required by IC § 4-13-2-14.8, payments to the Contractor shall be made via electronic funds transfer in accordance with instructions filed by the Contractor with the Indiana Auditor of State.

All other matters previously agreed to and set forth in the original Contract and not affected by this Amendment shall remain in full force and effect.

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Non-Collusion and Acceptance

The undersigned attests, subject to the penalties for perjury, that the undersigned is the Contractor, or that the undersigned is the properly authorized representative, agent, member or officer of the Contractor. Further, to the undersigned's knowledge, neither the undersigned nor any other member, employee, representative, agent or officer of the Contractor, directly or indirectly, has entered into or been offered any sum of money or other consideration for the execution of this Contract other than that which appears upon the face hereof**. Furthermore, if the undersigned has knowledge that a state officer, employee, or special state appointee, as those terms are defined in IC § 4-2-6-1, has a financial interest in the Contract, the Contractor attests to compliance with the disclosure requirements in IC § 4-2-6-10.5.**

Agreement to Use Electronic Signatures

I agree, and it is my intent, to sign this Contract by accessing State of Indiana Supplier Portal using the secure password assigned to me and by electronically submitting this Contract to the State of Indiana. I understand that my signing and submitting this Contract in this fashion is the legal equivalent of having placed my handwritten signature on the submitted Contract and this affirmation. I understand and agree that by electronically signing and submitting this Contract in this fashion I am affirming to the truth of the information contained therein. I understand that this Contract will not become binding on the State until it has been approved by the Department of Administration, the State Budget Agency, and the Office of the Attorney General, which approvals will be posted on the Active Contracts Database: https://secure.in.gov/apps/idoa/contractsearch/

In Witness Whereof, the Contractor and the State have, through their duly authorized representatives, entered into this Contract. The parties, having read and understood the foregoing terms of this Contract, do by their respective signatures dated below agree to the terms thereof.

Arcadian Health Plan, Inc,
d.b.a. Humana Healthy Horizons in Indiana

By: DocuSigned by: DB95BFEA315A4E5... (signature)

Title: xHumana Medicaid President

Date: 6/17/2025 | 07:39 PDT

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

By: DocuSigned by: Miller,Eric-405 5D870ABF9BAF4C5...

Title: Deputy Secretary

Date: 6/18/2025 | 10:42 PDT

Electronically Approved by: Indiana Office of Technology By: (for) Jeffrey K. Allen, Acting Chief Information Officer	Electronically Approved by: Department of Administration By: (for) Brandon Clifton, Commissioner
Electronically Approved by: State Budget Agency By: (for) Chad Ranney, State Budget Director	Electronically Approved as to Form and Legality: Office of the Attorney General By: (for) Theodore E. Rokita, Attorney General

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

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 PathWays for Aging (PathWays) 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 PathWays 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 PathWays program. Definitions for terms cited throughout the Scope of Work are listed in Exhibit 5A unless otherwise specified.

1.0 Background

The Indiana Family and Social Services Administration (FSSA) manages the PathWays program, which will serve approximately 106,000[1] Hoosiers. Indiana's PathWays program 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 3A. 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.

In developing PathWays, 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

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

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- 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 PathWays MCE Policies and Procedures Manual as updated and amended periodically.

1.1 Indiana PathWays for Aging (PathWays) 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 PathWays 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 PathWays:

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

FSSA PathWays Program Quality Goals

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

Goal 2: Ensuring Smooth Transitions – Ensure continuity of care and seamless experiences for members as they transition into the Pathways 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 members 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 PathWays program. For each goal, FSSA will establish focus areas, objectives, and performance targets which will evolve over time to reflect the maturation of the PathWays 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 PathWays 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 PathWays 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 PathWays 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 PathWays Goals. The State expects Contractors to align their resources toward achieving improvement in these goal areas. Examples include:

- 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

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The Contractor will be required to actively collaborate with the State and other PathWays 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 PathWays 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 assessment

Initial Objectives for PathWays Program Quality Goals

To actively support the PathWays 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 2A.

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 PathWays program. The FSSA Division of Family Resources (DFR)

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makes Medicaid 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: -In a nursing facility -Receiving hospice services
Excluded	-Partial Benefit Dually-Eligible individuals (QMB-only, SLMB-only, QI, QDWI) -Anyone under 60 years of age -Anyone under 60 years of age on the Health and Wellness waiver, in a nursing home, or receiving hospice care -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*

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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 3A Covered Benefits.

- *Residency*

  To be eligible for PathWays, 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 while pending enrollment in PathWays. The enrollment broker will be responsible for providing choice counseling to the member. 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). See Member Disenrollment from MCE (Section 5.2.5) for members' rights to disenroll and change MCEs.

- *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

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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.

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4. Providing Information that May Affect Eligibility

Members have a responsibility to report 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

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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 PathWays. 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)). Long-term care claims are not 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. The member is not required to pay the provider until the expense has been included in the waiver liability summary notice. The Contractor must be available to answer questions for members and their authorized representatives as to how the claims were applied to the liability.

- 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 coinsurance or copayment, Medicare 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.

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- 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 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 patient 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 CFR 435.726. Patient liability is imposed in accordance with 42 CFR 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.

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1. 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 regarding claims. If the member has questions regarding the calculation of the penalty, they should be referred to the DFR.

8. Suspensions

a. Medicaid Resource Suspension - for Medicaid members residing in a nursing home or on HCBS waivers, if a change in circumstances causes temporary resource or asset ineligibility for Medicaid, the member will have Medicaid suspended for up to two months by FSSA. If the member is eligible before the end of the suspension period, eligibility for Medicaid will be reinstated without a reapplication. If after the suspension period the recipient remains ineligible, Medicaid will be discontinued.

b. Incarceration/Psychiatric Admission - for Medicaid members who become incarcerated or admitted to a psychiatric facility that results in ineligibility, the individual's Medicaid is suspended. The individual's Medicaid is suspended until the member is released from the facility.

9. Member Cost Sharing Requirements

a. Medicaid cost-sharing involves certain Medicaid members contributing a small percentage of the cost to maintain their coverage. This can include copays paid directly at the time of medical services and monthly premiums paid by invoice. The Contractor shall adhere to State and Federal law, the State Plan, and the requirements set forth in 42 CFR 447.50 through 447.57 when imposing any cost sharing charges on members.

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).

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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.

Per 42 CFR 438.332(b), The Contractor must authorize NCQA to provide the State a copy of its most recent accreditation review including: its accreditation status, survey type, and level (as applicable); recommended actions or improvements, corrective action plans, and summaries of findings; and the expiration date of the accreditation. As required by 42 CFR 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 PathWays 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 PathWays 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

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- 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 the PathWays program. The Contractor must employ qualified staff to achieve compliance with contractual requirements and performance metrics.

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

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. Per 42 CFR 455.104(b)(4), the Contractor shall submit the name, address, date of birth, and SSN of any managing employee of the Contractor. FSSA reserves the right to approve or disapprove all initial and replacement key staff prior to their assignment to PathWays. 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 PathWays program. This Officer shall, at a minimum, be responsible for ensuring that the Contractor meets the State's requirements for financial performance and reporting.

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Compliance Officer – The Contractor must 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 PathWays 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 must 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 PathWays 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 must 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 Improvement and Utilization Management programs, including, but not limited to, monitoring, corrective actions, and other quality improvement, 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 improvement 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

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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 PathWays 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 must employ a Member Services Manager who is dedicated full-time to member services for the PathWays 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 Improvement 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, and member eligibility. 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 must employ a Provider Services Manager who is dedicated full-time to the PathWays 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.

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Special Investigation Unit Manager – The Contractor must 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 must employ an LTSS Program Manager who is dedicated full-time to the PathWays Program. The LTSS Program Manager shall, at a minimum, oversee and be responsible for all the PathWays 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 Improvement Manager – The Contractor must employ a Quality Improvement Manager who is dedicated full-time to the PathWays program. The Quality Improvement Manager shall, at a minimum, be responsible for directing the activities of the Contractor's quality improvement staff in monitoring and auditing the Contractor's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Quality Improvement 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 PathWays. For more information regarding the quality management requirements, see Section 7.0.

Utilization Management Manager – The Contractor must employ a Utilization Management Manager who is dedicated full-time to the PathWays 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

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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 Coordination Manager dedicated full-time to the PathWays 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 Coordination Manager must, at a minimum, be an Indiana licensed registered nurse or an Indiana licensed Master's level social worker with prior experience in LTSS or working with the program population, and at least three years of management experience in providing care coordination to a variety of populations. 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 Coordination 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 Manager, Provider and Member Services Managers, and with State staff as necessary, to communicate to providers and members. The Care Coordination Manager will provide input, as requested by the State, at State-level meetings.

Service Coordination Manager – The Contractor must employ a Service Coordination Manager dedicated to the PathWays program. This Manager must, at a minimum, have three years management experience and have a Bachelor's and/or Master's degree in social work, gerontology, counseling, psychology, or nursing; or a RN Licensure with one year experience in Human Services; or Bachelor's degree in any field with a minimum of 2 years full time, direct service experience with the elderly or disabled which includes assessment, care plan development, and monitoring. 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 Manager shall work in partnership with the Care Coordination Manager and supervise the service coordinators.

Behavioral Health Manager – The Contractor must 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 improvement, 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

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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 must 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 PathWays 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 must 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 PathWays 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.

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Transition Coordinator – The Contractor must employ a Transition Coordinator located in Indiana dedicated full-time to the PathWays 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 PathWays 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 must 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 must 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.

HCBS Incident Management Manager – The Contractor must employ a full-time HCBS Incident Management Manager, located in Indiana and dedicated to the PathWays program, who will oversee the reportable incident process and the HCBS Incident Management staff. HCBS Incident Management Manager will

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collaborate with Quality and Provider Relations staff to design and implement provider training on reporting and investigating incidents. The HCBS Incident Management Manager is required to report to the Quality Management Committee on a regular basis regarding analysis and trending of HCBS incidents and actions taken to prevent future incidents from occurring. The HCBS Incident Management Manager shall have experience in HCBS and LTSS services. This position must have experience in reviewing incidents and investigations. This position is responsible to perform regular incident reporting audits to ensure incidents are thorough and complete. This position is required to be trained in person centered principles.

Non-Emergent Medical Transportation (NEMT) Manager – The Contractor must employ a full-time Non-Emergent Medical Transportation (NEMT) Manager dedicated to the PathWays 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 Improvement Staff dedicated to performing quality management and improvement activities, participating in the Contractor's internal Quality Assessment and Performance 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 of which a minimum of seventy (70) percent are 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 PathWays program must have experience in long term services and supports or the care of older adults.

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Case Management Supervisor(s) who is an Indiana licensed registered nurse or an Indiana licensed Master's level social worker/therapist with a minimum of three years of case management experience. The Case Management Supervisor(s) 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 for complex case management and RCP must be (1) an Indiana licensed registered nurse (2) an Indiana licensed Master's degree in social work or therapist, and have training, expertise, and experience in providing case management and care coordination services for individuals, including specialized populations such as older adults and/or individuals with physical or developmental disabilities and/or individuals determined to have a serious mental illness (SMI).

Service Coordinators shall be located in Indiana while performing job responsibilities. Service Coordination is a vital service to members and the Service Coordinators should be engaged in the communities they serve. The Contractor must employ Service Coordinators experienced in meeting the needs of people with disabilities regardless of age and vulnerable populations with Chronic and/or Complex Conditions. A Service Coordinator must have an undergraduate and/or graduate degree in social work or a related field, or be a Registered Nurse, Licensed Practical Nurse, Advanced Nurse Practitioner, or a Physician Assistant.

Transition Coordination Staff who are 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 that is part-time or on-call with qualifications and certification as outlined by ASAM for behavioral health utilization management activities.

Member Services Representatives of which a minimum of seventy (70) percent 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

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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 of which a minimum of seventy (70) percent are located in Indiana. The member marketing and outreach staff shall manage marketing and outreach efforts for the PathWays 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 PathWays 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 is 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

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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. Certified Health Education Specialists are preferred.

Website Staff to maintain and update the Contractor's member and provider websites, and respective portals. Staff must be trained in ADA compliance and the system requirements outlined in Section 9.0 Information Technology (IT) Systems.

Housing Coordinator – The Contractor must have a Housing Coordinator located in Indiana. The Housing Coordinator will 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. 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.

Nutritionist – The Contractor is required to have access to an Indiana licensed nutritionist or dietician to consult on the Contractor's Indiana Medicaid lines of business. 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 may help identify members who are at nutritional risk in accordance with medical standards and provide intervention recommendations to the Contractor's care

Workforce Development Administrator – The Contractor must have a Workforce Development Administrator, located in Indiana, who is responsible for coordinating and overseeing workforce development (WFD) activities. 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.

Community Health Workers (CHW) – The Contractor must employ or contract CHWs, located in Indiana, to assist in outreach and engaging members in appropriate health services and providing health education and disease self-management, with emphasis placed on preventive care within the population health program. CHWs should be deployed when Contractor has difficulty reaching members with high needs.

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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 PathWays program. Staff training shall include, but is not limited to:

- An overview of the PathWays 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(b)(1)(ii)(H), 42 CFR 489.102(a)(5) and 42 CFR 438.3(j), 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 PathWays program for all care coordinators and service coordinators. The Contractor shall also ensure all applicable subcontractors provide such training to their relevant staff;

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- Training and education to understand abuse, neglect, exploitation, and prevention including the detection, reporting, investigation and remediation procedures and requirements;

- 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; and

- 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 PathWays 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, section 1932(d)(1) of the Social Security Act, SMDL 6/12/08 and SMDL 1/16/09, which prohibits affiliations with individuals debarred by Federal agencies, the Contractor must not knowingly have a relationship with the following:

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

- An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

Per 42 CFR 438.610(a) and 42 CFR 438.610(c), the relationships for debarred individuals and affiliates include directors, officers or partners of the Contractor, a subcontractor of the contractor as governed by 438.230, persons with beneficial ownership of five percent (5%) or more of the Contractor's equity, or a network provider 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 Section 1932(d)(1) of the Social Security Act, 42 CFR 438.608(C)(1), SMDL 6/12/08, SMDL 1/16/09, and Exec. Order No. 2549, the Contractor shall provide written disclosure of any of the prohibited relationships described above. Per 42 CFR

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438.610(d), 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 PathWays 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 PathWays 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 PathWays line of business separately. The financial performance reporting requirements are listed in Section 10.1 and are further described in the PathWays MCE Reporting Manual which shall be provided by the Contract award date.

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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. Per 42 CFR 438.604(a)(4), 42 CFR 438.606, and 42 CFR 438.116, the Contractor shall submit documentation on the basis of which the State determines that the Contractor has made adequate provision against the risk of insolvency.

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 per 42 CFR 438.106(a) and section 1932(b)(6) of the Social Security Act.

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 per 42 CFR 438.116(b) and section 1903(m)(1) of the Social Security Act.

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

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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 PathWays 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 PathWays-specific information, FSSA may terminate the

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Contract. The Contractor shall provide documentation that its accounting records are compliant with IDOI standards.

The Contractor shall make full disclosure, and the State shall review, ownership and control information for the Contractor, any subcontracting entities or providers as required by 42 CFR 455.100 through 455.106 as directed in the MCE Policies and Procedures Manual and as required by 42 CFR 438.604(a)(6), 42 CFR 438.606, 42 CFR 455.104(b), 42 CFR 438.230, 42 CFR 438.608(c). 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. Per 42 CFR 455.104, the Contractor shall submit the date of birth and Social Security Number (SSN) of any individual with an ownership or controlling interest in the Contractor and its subcontractors. The Contractor shall submit other tax identification number of any corporation with an ownership or controlling interest in the Contractor and any subcontractor in which the Contractor has a five percent (5%) or more controlling interest. The Contractor shall submit the name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and post office box address. Additionally, annual audits shall include an annual actuarial opinion of the Contractor's incurred but not received claims (IBNR) specific to the PathWays 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 must 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 42 CFR 75.361, 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.

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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;

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- 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; or

- 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.

Per Section 1903(m)(4)(B) of the Social Security Act, any reports of transactions between the Contractor and parties in interest that are provided to the State, or other agencies, shall be made available to the Contractor's members upon reasonable request.

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.

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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 6A. 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 State will deny payments for new enrollees when, and for so long as, payment for those enrollees is denied by CMS. CMS may deny payment to the State for new enrollees if its determination is not timely contested by the Contractor per 42 CFR 438.726(b) and 42 CFR 438.730(e)(1)(ii). 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 PathWays-related revenue and expenses and non-PathWays 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

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- 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
- 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(l), 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).

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2.7.7 Medical Loss Ratio (MLR)

The MLR shall be calculated as follows:

Each reporting year, consistent with MLR standards as required in 42 CFR 438.8, the Contractor shall calculate, attest to the accuracy, and submit to FSSA its Medical Loss Ratio (MLR). The MLR submission must fully comply with 42 CFR 438.8(d)-(n) which specifies that the MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)). In accordance with 42 CFR 438.604(a)(3), 42 CFR 438.606, and 42 CFR 438.8, the Contractor is required to submit data on the basis of which the State determines the compliance with MLR requirements. In addition, the State provides the following clarifications:

- The MLR calculation shall be performed separately for each MLR reporting year per 42 CFR 438.8(a).
- The MLR calculation shall be performed separately for each program. The MLR for the PathWays program shall be calculated separately from other managed care programs.
- For purposes of MLR reporting, the Contractor should aggregate data for all Medicaid eligibility groups covered under the contract with the state.
- Timing
    - For each MLR reporting year, the Contractor must submit the MLR report within 12 months of the end of the reporting year, reflecting nine (9) months of incurred claims run-out.
    - The Contractor must require any third-party vendor providing claims adjudication services to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner.
- The MLR report submitted by the contractor for each reporting year must include the following elements, as defined in 42 CFR 438.8:
    - Number of member months in the reporting year
    - Premium revenue, including nursing facility provider supplemental payments
    - Taxes
    - Licensing fees
    - Regulatory fees
    - Incurred claims
    - Expenditures for Quality Improvement activities

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- Expenditures for Fraud prevention activities as defined in 42 CFR 438.8(e)(4)
- Non-claims costs
- Any credibility adjustment applied
- Remittance owed to the state, if any
- A comparison of the information reported on the MLR with the audited financial report
- A description of the aggregation method used to calculate total incurred claims
- A description of the methodology used to allocate expenses
- An attestation as to the accuracy of the calculation, in accordance with MLR standards.

- Incurred Claims
  - Incurred claims submitted for each reporting year should include total incurred claims for the reporting year, and should not include claims incurred in prior years, regardless of when they were paid.

- Incurred claims reported in the MLR should relate only to members who were enrolled with the Contractor on the dates of service, based on data and information available on the reporting date (Claims for members who were retroactively disenrolled should be recouped from providers and excluded from MLR reporting). Under Sub-Capitated or Sub-Contracted arrangements, the MCE may only include amounts actually paid to providers for covered services and supplies as incurred claims. The non-benefit portion of sub-capitated and sub-contracted payments should be excluded from incurred claims. The MCE should ensure all subcontracts provide for sufficient transparency to allow for this required reporting.

- Expenditures may not be duplicated across expense categories or contracts.
  - Each expenditure must be reported under only one expense category, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.
  - Expenditures that benefit multiple contracts or populations must be reported on a pro rata basis.
  - Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
  - Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims,

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must be borne solely by the reporting entity and are not to be apportioned to other entities.

- Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

- Credibility adjustment
  - Contractors may not add a credibility adjustment to the calculated MLR if the reporting year experience under the contract is fully credible.
  - Contractors may add a credibility adjustment to the calculated MLR if the MLR reporting year experience under the contract is partially credible.
  - The credibility adjustment should be calculated using credibility factors published by CMS, as specified in 42 CR 438.8(h)(4).
  - The credibility adjustment should be added to the reported MLR calculation before calculating the remittance, if any.
  - If the Contractor's experience under the contract is non-credible, it is presumed to meet or exceed the MLR calculation standards.

The Contractor shall maintain, at minimum, a MLR of ninety-three percent (93%) for the PathWays line of business per 42 CFR 438.8. However, a sliding scale minimum MLR will be implemented to address situations where the Contractor has a higher-than-expected percentage of acute care members during the contract year. Acute care members are defined as having payments in any of the following payment rate cells: Acute Dual, Acute Non-Dual, LTSS Net Zero Dual, and LTSS Net Zero Non-Dual. If Contractor in the PathWays program has more than 75% acute care average enrollment over the course of the contract year, its minimum MLR will be adjusted based on the table below. For percentages between those listed in the table, the minimum MLR would be interpolated, rounded to the nearest 0.1%.

FIGURE 1: MINIMUM MLR SLIDING SCALE

MLTSS - Acute (Non-LTSS) Enrollment Percentage	Minimum MLR
<=75%	93.0%
85%	92.0%
90%	91.0%
>=94%	90.0%

The Contractor is required to submit MLR reporting as described in the MCE Reporting Manual for PathWays. In any instance where the State makes a retroactive change to the capitation payments for the MLR reporting year where the MLR report has already been submitted, the Contractor must re-calculate the MLR for all reporting years affected by the change and submit a new MLR report meeting the applicable requirements per 42 CFR 438.8(m) and 42 CFR 438.8(k).

If the Contractor has less than 75% acute care average enrollment in the PathWays program over the course of the contract year, FSSA shall recoup excess capitation

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paid to the Contractor in the event that the Contractor's MLR is less than ninety-three percent (93%) for the PathWays line of business.

If the Contractor has more than 75% acute care average enrollment in the PathWays program over the course of the contract year, the Contractor's minimum MLR threshold will be calculated in accordance with Figure 1, and FSSA shall recoup excess capitation paid to the Contractor in the event that the Contractor's MLR is less than the calculated minimum MLR threshold for the PathWays line of business.

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 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.

2. Non-HAF eligible hospitals

    i. 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.

    ii. Non-contracted providers: MCEs shall pay the following: One hundred percent (100%) of the Medicaid APR DRG rates for Inpatient and one hundred percent (100%) 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

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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, midwives, 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 that is not owned or operated by an NSGO.

The Contractor is responsible for making quarterly payments to NSGOs and nursing facilities as directed by the State. The Contractor must have the NSGOs and nursing facilities established in their financial payment system (accounts payable) to perform an electronic funds transfer (EFT) within 3-5 days of receiving the funds from the State or State's fiscal agent.

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.

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2.8.5 Physician and Ancillary Minimum Fee Schedule

Physician and ancillary providers must be reimbursed at no less than the Medicaid fee schedule effective during the rating period.

2.9 Subcontracts

The term "subcontract(s)" includes contractual agreements between the Contractor and health care providers or other ancillary medical providers.

Per 42 CFR 438.2, a provider is defined as any individual, organization, or institution (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, ambulatory surgical centers, outpatient clinics etc.) that provides medical services to beneficiaries covered under this Contract.

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.

The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State, notwithstanding any relationship(s) with any subcontractor per 42 CFR 438.230(b)(1) and 42 CFR 438.3(k).

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. Such waiver shall not constitute a waiver of any subcontract requirement. 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 provide to FSSA the findings of all subcontractor performance monitoring and reviews upon request and shall notify FSSA any time a subcontractor is placed on corrective action. 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

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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 LTSS and HCBS utilization management activities. The Contractor shall give FSSA a written request and submit a draft contract or model provider agreement at least sixty (60) calendar days prior to the use of a subcontractor. 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 sixty (60) 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

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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 sixty (60) 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 PathWays 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 per 42 CFR 438.230(c)(1)(iii). 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.

- For the purposes of an audit, evaluation, or inspection by the State, CMS, the DHHS Inspector General, the Comptroller General or their designees, the subcontractor shall make available for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, its premises, physical facilities, equipment, books, records contracts, computer, or other electronic systems relating to its Medicaid enrollees per 42 CFR 438.230(c)(3)(iii) and 42 CFR 438.3(k). This contract term shall specify that if the State, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the above State and Federal agencies may inspect, evaluate, and audit the subcontractor at any time.

- 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.

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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 subcontract shall specify the activities and obligations, and related reporting responsibilities per 42 CFR 438.230(c)(1)(i)-(ii) and 42 CFR 438.3(k).

- 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 an approved subcontract arrangement for utilization management activities, the Contractor shall ensure 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)(4) 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

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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 shall not subcontract with the External Quality Review (EQR) or Enrollment Broker contractors.

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 2A 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 PathWays 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.

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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, 42 CFR 438.208(b)(6), and 42 CFR 438.224). The Contractor shall also comply with all other applicable state and federal privacy and confidentiality requirements.

2.11 Internet Quorum (IQ) Inquiries

FSSA receives inquiries and complaints (IQ inquiries) from various sources, including but not limited to, providers, members, legislators or other constituents which require Contractor research, response and resolution. Additionally, inquiries may be sent to Contractor when FSSA is seeking information, clarification, or explanation. When forwarding an IQ inquiry to the Contractor for a response, FSSA shall designate as an IQ and will identify when the Contractor's response is due. 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 2A.

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 thirty (30) calendar days in advance member and provider notification. The request must contain, at minimum, information regarding the nature of the change, the rationale for the change, proposed effective date, and sample member and provider notification materials. All material changes must be communicated to members or providers at least thirty (30) days prior to the effective date of the change. The provider notice period for material changes that affect certain provider procedures are 45 days prior to effective date (see Section 6.12). These notice periods may not be concurrent with MCE's request to FSSA for the material change.

2.13 Future Program Guidance

The Contractor shall operate in compliance with the PathWays Policies and Procedures Manual and 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

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Contractor's responsibilities, as set forth in this Scope of Work, will be made through the Contract amendment process.

The Indiana PathWays for Aging MCEs are required to maintain a fully developed companion D-SNP that operates statewide. The State shall only contract with aligned D-SNPs with the same parent company as the Indiana PathWays for Aging MCE. The State will require exclusively aligned enrollment effective January 1, 2026, for full-benefit dual eligible Indiana PathWays for Aging members choosing to enroll in Indiana PathWays for Aging Dual Care (PathWays Dual Care) product as defined under 42 CFR 422.2

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.

The Contractor and the Contractor's subcontractors shall retain, as applicable enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period of no less than ten (10) years per 42 CFR 438.3(u).

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, the Indiana State Plan, 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

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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.

The State will require the Contractor to complete the readiness review for D-SNP in preparation for plan year 2026 by December 31, 2025. If the Contractor fails to satisfactorily pass the D-SNP readiness review, the State may delay member enrollment and/or may require other remedies (including, but not limited to contract termination), and the Contractor shall be responsible for all costs incurred by the State as a result of such delay.

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

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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

Indiana's PathWays for Aging population includes individuals dually-eligible for both Medicare and Medicaid. Alignment and integration of these two payer sources provides better coordination of benefits and removes barriers to care. Effective January 1, 2026, the State will require exclusive alignment. Exclusive alignment is when a State policy limits a D-SNP's membership to individuals with aligned enrollment (see 42 CFR 422.2). Aligned enrollment is when dually eligible members Medicare and Medicaid benefits are provided under a single entity. The Contractor shall support the State with efforts to establish Prioritized Alignment in advance of the Pathways Dual Care FIDE-SNP launch. Prioritized Alignment will occur in 2025 and result in the re-assignment of unaligned Medicaid members to align individuals with their chosen D-SNP.

Integration refers to a delivery system that provides the full alignment 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.

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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 PathWays enrollees consistent with the State's vision and goals.

PathWays 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, ongoing audits, quality and outcomes monitoring, data reporting, member enrollment, member program transitions, member materials, member services helpline, 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, 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;

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- A dedicated helpline to take member phone calls and answer member questions about Medicare coverage, including those related to the contractor's aligned D-SNP plan.

2. Provider education that covers at a minimum:

   - Dual-eligibility in Indiana for Medicare and Medicaid, including information on Exclusively Aligned Enrollment

   - 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. 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 PathWays 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.

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. 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 and maintain Centers for Medicare & Medicaid Services (CMS) approval to operate a Dual Eligible Special Needs Plan (D-SNP) in Indiana. The Contractor shall obtain CMS approval annually to operate a D-SNP in Indiana. Failure to maintain their CMS approved D-SNP status will exclude the Contractor from participating in the PathWays program.

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

The Contractor D-SNP shall:

- Operate an exclusively aligned plan that is limited to full-benefit dually eligible (FBDE) enrollment, when applicable;
- Offer a plan benefit package that enrolls only partial-dually eligible Medicaid enrollees (QMB-only, SLMB-only, QI, QDWI);
- Offer a 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 PathWays;
- Maintain a statewide service area that operates in all Indiana counties;
- Have obtained prior CMS approval for default enrollment of members from their aligned PathWays 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; and
- Meet SMAC contract requirements. Failure may result in FSSA assessing authorized remedies for the Contractor's non-compliance as listed in Exhibit 2A.

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. For aligned D-SNP members see Section 4.17.2 ICT Participant Roles and Responsibilities for additional requirements.

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 PathWays 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 PathWays 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.

No later than January 1, 2026, 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). The single ID card is for accessing all PathWays Dual Care D-SNP and PathWays services and benefits. The Contractor shall include the State Medicaid number on the integrated

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FIDE-SNP ID card and the health plan member ID number. The Contractor shall not include the Medicare Beneficiary ID. The ID card must include a single member services/customer service phone number. The Contractor shall include the health plan member ID number on non-FIDE-SNP cards. The Contractor shall not include the Medicaid or Medicare Beneficiary ID number on the non-FIDE-SNP PBP member ID cards.

The Contractor is responsible for monitoring CMS information regarding dates of submission for all necessary D-SNP related documentation upon go-live and ongoing. It is also responsible for understanding all state-specific requirements for the SMAC and any other D-SNP related materials.

3.0 Covered Benefits and Services

The Contractor shall provide to its PathWays 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.

Medically Necessary is defined as services or supplies that are proper and needed for the diagnosis or treatment of the member's medical condition, are provided for the diagnosis, direct care, and treatment of the member's medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the member or the member's doctor. Medically necessary services include covered services that are required for the care or well-being of the patient and are provided in accordance with generally accepted standards of medical or professional practice to prevent disease, disability or other adverse conditions or their progression, or to prolong life. [See also 42 CFR 438.210(a)(5)]

A covered service is medically necessary if, in a manner consistent with accepted standards of medical practice, it is reasonably expected to:

- Not be more restrictive than the State Medicaid Fee for Service program, including Quantitative and Non-Quantitative Treatment Limits, as indicated in State statutes and regulations, the Contractor's and other State policies and procedures per 42 CFR 438.210(a)(5)(i).

- Address the prevention, diagnosis, and treatment of an enrollee's disease, onset of an illness, injury, condition, primary disability or secondary disability, and/or disorder that results in health impairments and/or disability per 42 CFR 438.210(a)(5)(ii)(A).

- Cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury or disability.

- Reduce or ameliorate the pain or suffering caused by an illness, injury, condition or disability.

- Cover services related to the ability for an enrollee to achieve age-appropriate growth and development per 42 CFR 438.210(a)(5)(ii)(B).

- Cover services related to the ability for an enrollee to attain, maintain, or regain functional capacity per 42 CFR 438.210(a)(5)(ii)(C).

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- Extend the opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice per 42 CFR 438.210(a)(5)(ii)(D).

The Contractor shall comply with sections 1903(i)(16)-(18) of the Social Security Act and is prohibited from paying for items or services (other than an Emergency item or service, not including items or services furnished in an Emergency room or a hospital):

- With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

- With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State plan.

With respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State on a continuing basis a surety bond as specified under paragraph (7) of section 1861(o) of the Social Security Act Per 45 CFR 156.115(a)(5), habilitative services and devices include health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples may include an individual who needs assistance with mobility or speech. These services may also include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitative services and devices include health care services and devices to help a member recover from an illness or injury. These services may be given by nurses and physical, occupational, and speech therapists. Examples may include working with a physical therapist to help a member walk and with an occupational therapist to help a member get dressed.

Per 42 CFR 440.20, outpatient hospital services mean preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

(1) are furnished to outpatients;

(2) are furnished by or under the direction of a physician or dentist; and

(3) are furnished by an institution that:

  (i) is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
  (ii) meets the requirements for participation in Medicare as a hospital; and

(4) may be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of “outpatient hospital services” those types of items and services that are not generally furnished by most hospitals in the State.

In accordance with 42 CFR 438.210(a)(2)-(3), 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. Per 42 CFR 438.210(a)(2), the Contractor must furnish covered services in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under Fee for Service (FFS) Medicaid. Costs for these services are the basis of the Contractor’s capitation rate and are, therefore, the responsibility of the Contractor. Coverage of services in amount, duration or scope may not be arbitrarily denied or reduced solely because of diagnosis, type of illness, or condition of the beneficiary per 42 CFR 438.210(a)(3)(ii). Coverage may not be arbitrarily denied or reduced and is subject to certain

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limitations in accordance with 42 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; the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20 (https://www.ecfr.gov/current/title-42/section-441.20).

Per 42 CFR 400.203, State Plan refers to the comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the Social Security Act, to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

The Contractor may cover services necessary for compliance with requirements for parity in mental health and substance use disorder benefits in 42 CFR Part 438, subpart K, identified with the analysis of parity compliance conducted by the State or the Contractor per 42 CFR 438.3(e)(1)(ii).

3.1 Covered Benefits and Services

Exhibit 3A of the Contract provides a general description of the PathWays benefit packages and the services and benefits that are available.

The Contractor shall not pay for organ transplants unless the Contractor follows the written standards included in the State Plan that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to members. For additional information, please see the following:

- https://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_3/3.1e.pdf
- https://provider.indianamedicaid.com/ihcp/StatePlan/Section_3/3.1.f.g.h.pdf

3.2 Self-referral Services

In accordance with state and federal requirements, the PathWays 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. Note that network is defined as a list of the doctors, other health care providers, and hospitals that the Contractor contracts with to provide medical care to its members. These providers are called "network providers" or "in-network providers." A provider that isn't contracted with the Contractor is called an "out-of-network provider." 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.

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PathWays members may self-refer to any IHCP provider qualified to provide the service(s). When PathWays 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 an amount not less than 100% 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 and 405 IAC 5 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 1-2-1 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. Contractors may place appropriate limits on the service for utilization control, provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used per 42 CFR 438.210(a)(4)(ii)(C). Family planning services also include sexually transmitted disease testing. 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.

    - Abortions and abortifacients are not covered family planning services except as allowable under the federal Hyde Amendment. Abortions are only covered if the pregnancy is the result of an act of rape or incest or a case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself which would, as certified by a physician, place the woman in danger of death unless an abortion is performed and in compliance with 42 CFR 441.202.

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- 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(b) and 42 CFR 438.114(c) and section 1852(d)(2) of the Act, 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), credentialed in psychiatric or mental health nursing (applicable education and board certification; and
    - Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option).

3.3 Drug Coverage

Prescription drugs including injections and infusions, certain over-the-counter drugs, pharmacy supplements and other specified products are benefits under the PathWays program to be covered by the Contractor. Per 21 CFR 203.3(y), prescription drug means any drug (including any biological product, except for blood and blood components intended for transfusion or biological products that are also medical devices) required by Federal law

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(including Federal regulation) to be dispensed only by a prescription, including finished dosage forms and bulk drug substances subject to section 503(b) of the Social Security Act.

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 follow the statewide unified preferred drug list (SUPDL) for the pharmacy benefit. The SUPDL will consist of the fee-for-service (FFS) PDL. Adoption of the SUPDL shall include alignment of prior authorization (PA), forms, and step edit and utilization edit criteria for drugs and drug classes that are part of the SUPDL. The Contractor will discontinue and not seek commercial discounts and commercial rebate agreements with pharmaceutical manufacturers for IHCP member pharmacy benefits. The Contractor may only set a Maximum Allowable Cost (MAC) rate on a multiple source drug available from at least two manufacturers. The MAC rate may not be applied when the brand product is preferred over available generics on the SUPDL.

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.

A contract holder may one time in a calendar year and not earlier than six months following a previously requested audit, request an audit of compliance with the contract. If requested by the contract holder, the audit shall include all requirements outlined in IC 27-1-24.5-25. However, in instances where the contract holder or the State Medicaid Agency receives a complaint of Medicaid Fraud or abuse from any source or identifies any questionable practices, a preliminary investigation, which may include an audit, will be conducted regardless of any prior audit pursuant to 42 CFR 455.14.

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

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

The Contractor shall provide for ninety (90) days of continuity of care for all pre-existing drug regimens for all new members. This will allow time for the PBM to work with the prescribing provider to negotiate future drug regimens.

The Contractor shall 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.

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3.3.1 Drug Rebates

The Contractor shall take all steps necessary to participate in, and support FSSA's participation in, federal and supplemental drug rebate programs by terminating, and not entering into, rebate agreements with its Pharmacy Benefit Managers (PBMs) or with manufacturers for any drugs.

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 PathWays 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 provide reports to the State to support rebate collection per 42 CFR 438.3(s)(2) and Section 1927(b)(1)(A) of the Social Security Act. 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, as well as the PathWays MCE Reporting Manual. 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.

Per 42 CFR 438.3(s)(2) and section 1927(b)(1)(A) of the Social Security Act, 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 PathWays MCE Reporting Manual.

The Contractor shall comply with 340B-related policies and procedures set forth in IHCP Provider Bulletin BT201413, dated April 1, 2014, and BT201754, dated August 15, 2017, and any updates hereto. 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. The Contractor must have procedures in place to exclude utilization data for drugs subject to discounts under the 340B Drug Pricing Program from the utilization reports submitted to the State. Specific plans for excluding utilization data should be detailed and agreed upon between the Contractor and the State and may use tools including, but not limited to, modifiers, billing instructions, and processes to correctly identify a 340B patient.

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.

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3.3.2 SUPDL and Formulary Requirements

For purposes of this section, the "formulary" is defined as the SUPDL and "non-formulary" is defined as covered outpatient drugs not included in the SUPDL.

The Contractor shall maintain a formulary (i.e., SUPDL) and covered non-formulary (i.e., non-SUPDL) drug lists for the Contractor's PathWays packages. The Contractor must use the SUPDL as its formulary and may not develop and use its own PDL for any therapeutic categories that are part of the SUPDL. The Contractor will be provided opportunities to offer feedback on the SUPDL to the State. The State shall provide the Contractor with thirty (30) calendar days' notice of any change to the SUPDL, except those changes resulting from a drug shortage, recall or discontinuation, and the Contractor shall have an additional thirty (30) calendar days to implement the change, including any system change. A drug that is on the SUPDL must have the same criteria and forms as the FFS PDL even if it is reimbursed as a medical claim.

The PathWays formulary and non-formulary 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 405 IAC 13-9. In accordance with CMS-2390-F and 42 CFR 438.210, the Contractor shall demonstrate prescription drug coverage consistent with the amount, duration, and scope of the fee-for-service program. Per 42 CFR 423.100, prescription drug coverage means coverage of Part D drugs that is either standard prescription drug coverage or basic alternative coverage.

The Contractor shall engage with the State process to develop universal medically necessary prior authorization criteria for IHCP. The Contractor shall follow the SUPDL prior authorization criteria for SUPDL drug classes. Per 42 CFR 419.81, preauthorization (or prior authorization) means the process through which a request for provisional affirmation of coverage is submitted to CMS or its contractors for review before the service is provided to the beneficiary and before the claim is submitted for processing. The Contractor shall implement the universal IHCP criteria into their program and may not utilize more restrictive criteria.

At least thirty-five (35) days before the intended implementation date of the initial formulary and non-formulary drug list, the Contractor shall submit its proposed formulary and non-formulary lists to OMPP. The OMPP shall submit the formulary and non-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 formulary and non-formulary covered drug lists. The DUR Board will provide a recommendation regarding approval of the formulary and non-formulary drug lists in accordance with the terms of IC 12-15-35-46. OMPP will approve, disapprove or modify the formulary and non-formulary covered drug lists 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 submit any changes to the contents of the approved non-formulary drug list and any changes to prior authorization or medical necessity criteria applied to the non-formulary drug list to OMPP at least sixty (60) days prior to the intended implementation date. OMPP may disapprove or modify the proposed changes within thirty (30) days of receipt. If no response is received from OMPP within thirty (30) days, the Contractor may implement the proposed changes.

The Contractor shall utilize a Pharmacy and Therapeutics Committee which shall meet regularly to make recommendations for changes to neutral non-formulary drugs

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formulary. The formulary (i.e., SUPDL) and non-formulary (i.e., non-SUPDL) covered drug lists shall be made readily available to providers in the Contractor's network and to members by linking to the Pharmacy Services page on https://www.in.gov/medicaid/. The formulary and non-formulary covered drug lists shall be updated and posted on or before the intended implementation date 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 and formulary SUPDL and non-formulary drug lists and covered drugs to prescribers through electronic medical records (EMRs) and e-Prescribing applications. Refer to 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 PDL and formulary as well as the utilization of e-Prescribing technologies to ensure appropriate prescribing for members based on the member's benefit plan. The Contractor shall assure that non-drug products approved for use in compounding are not subject to rebating manufacturer requirements.

Per 42 CFR 438.10(i)(1)-(2), the Contractor shall make available in electronic or paper form, the covered drug list(s) of medications including the reference brand and generic names of each drug as well as what tier each drug is on.

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 PathWays 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

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 PathWays MCE Reporting Manual for more information on pharmacy reporting requirements.

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All mental health drugs described in IC 12-15-35.5 are considered preferred and included on the SUPDL. The Contractor shall comply with all SUPDL requirements pertaining to mental health drugs.

The Contractor shall comply with any additional reporting requests required for submission to the DUR Board and MHQAC.

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. OMPP may identify therapeutic drug classes or specific drug products for which the Contractor may be required to bring to the DUR Board for review prior to the implementation of any changes in coverage or utilization management criteria.

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 per 42 CFR 438.210(d)(3). Additionally, the Contractor shall provide for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug as required under 42 U.S.C 1396r- 8(d)(5)(B) without prior authorization. The Contractor shall allow for 90-day supply for maintenance drugs (does not apply to specialty drugs). 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 shall implement prior authorization for the SUPDL 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. For non-formulary covered drug classes, the Contractor may apply 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 of drugs 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 in the formulary or non-formulary covered drug lists 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 438.3(s) and the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F), any medical necessity criteria applied by the Contractor may not be more stringent than any established FFS criteria for non-formulary covered drug classes. For formulary (SUPDL) drug classes, the Contractor shall follow the SUPDL criteria.

The Contractor shall provide online and real-time rules-based point-of-sale (POS) claims processing for pharmacy benefits. In accordance with 42 CFR Part 456, subpart K and 42 CFR 438.3(s)(4), the Contractor shall operate drug utilization review as described in this section. 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.

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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.

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

    - The MCE shall immediately report to OMPP claims processing outages experienced by the MCE and/or its PBM. This includes a root cause analysis of the outage to the State in a timely manner.

    - Claims processing errors and a root cause analysis of the claims processing error to the State 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.

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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 PathWays members.

3.3.6 Carve-Out of Select Drugs

Exhibit 3A 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 and section 1902(a)(85) of the Social Security Act, the Contractor shall implement and maintain the following processes and standards for:

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; and

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.

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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;

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; and

4. The PBM will not include administrative costs, fees, or other expenses in the amounts paid for each claim reports to the Contractor. The reported cost per claim shall only include the ingredient cost and dispensing fee reimbursed to the provider. Administrative costs, fees, or other expenses, including those charged to the Contractor on a per claim basis, shall be reported to the Contractor separately as required by 42 CFR 438.3(s)(8).

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 and emergency medical transportation without the need for prior authorization or the existence of a contract with the emergency care provider per 42 CFR 438.114(c)(1)(i). Per 405 IAC 5-2-9, emergency service is defined as a service provided to a member after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

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Per 836 IAC 1-1-1, emergency medical transportation means the transportation of emergency patients by ambulance and the administration of basic life support to emergency patients before or during such transportation.

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. Per 42 CFR 438.114, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part.

The Contractor shall cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations under section 1867 and at 42 CFR 489.24, which sets special responsibilities for hospitals in emergency cases, provided to a member who presents to an emergency department with an emergency medical condition. The Contractor shall also comply with all applicable emergency services requirements specified in IC 12-15-12. The Contractor shall reimburse out-of-network providers no more than the Medicaid fee-for-service (FFS) rate per section 1932(b)(2)(D) of the Social Security Act, 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 per 42 CFR 438.114(d)(1)(i);

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 per 42 CFR 438.114(c)(1)(ii);

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 per 42 CFR 438.114(d)(1)(ii);

5. Refuse to cover services if a representative of the Contractor instructed the member to seek Emergency Services per 42 CFR 438.114(c)(1)(ii);

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6. Hold the member liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition per 42 CFR 438.114(d)(2); nor

7. Per 42 CFR 438.114(d)(3), 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 January 30, 2020 (BT202009) and any updates thereto.

Effective July 1, 2024, 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-Q, 69, 70A-C, and 72A-C on the UB04 and 21A-L 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. Physician services include services provided by an individual licensed under State law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included (see also: 42 CFR 414.2).

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. Emergency room care includes care given for a medical emergency when a member believes that their health is in serious danger and every second counts (see also: 42 CFR 405.440).

- 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.

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- 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.

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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 3.3 Drug Coverage), including individual and group counseling and all covered outpatient drugs indicated for Smoking Cessation and Tobacco Dependence Treatment. Licensed practitioners within their scope of license under Indiana law may prescribe one or more modalities of treatment. Practitioners must include individual and group 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. The Contractor shall comply with policies and procedures set forth the IHCP Provider Bulletin regarding Tobacco Dependence individual and group counseling sessions dated November 15, 2022 (BT2022100), and any updates thereto.

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 PathWays program. The Contractor shall be responsible for managing and reimbursing all such services in accordance with the requirements in this section. The Contractor shall provide timely access to behavioral health screening, assessment, referral and treatment services, including outpatient services as well as inpatient psychiatric hospital services, inpatient drug and alcohol detoxification, inpatient drug and alcohol rehabilitation, and residential treatment services for opioid use disorder (OUD) and substance use disorder (SUD) apart from treatment rendered in a State Hospital as described in Section 3.21.1. As described in Section 3.24, the Contractor is encouraged to develop and purchase enhanced services which can provide services in a less restrictive setting and/or which would result in improved outcomes for members.

In furnishing mental health or substance use disorder benefits, including any applicable utilization restrictions, the Contractor shall comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) prohibiting the application of more restrictive limits to mental health/substance use disorder benefits than to medical/surgical benefits. Compliance with the MHPAEA and State requirements includes, but is not limited to:

1. Not applying any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor) per 42 CFR 438.910(b)(1).

2. If a member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits shall be provided to the member in every classification in which medical/surgical benefits are provided per 42 CFR 438.910(b)(2).

3. Not applying any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care,

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prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification per 42 CFR 438.910(c)(3).

4. 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. Per 42 CFR 438.910(d), the Contractor shall not impose Non-Quantitative Treatment Limits (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

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

6. 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.

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

8. Providing out-of-network coverage for mental health or substance use disorder benefits. The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than those applied for out-of-network medical/surgical benefits in the same classification as required by 42 CFR 438.910(d)(3).

9. Coordinating transition of care for members going from a higher to a lower level of care. Coordinating transition of care to approved lower level of care for patients who are, due to lack of medical necessity, denied a higher level of care.

The Contractor shall assure that behavioral health services are integrated, regardless of 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.

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

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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.

The Contractor shall ensure the availability of behavioral health crisis intervention services twenty-four (24) hours a day, seven (7) days a week. The Contractor shall maintain processes for crisis intervention.

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 405 IAC 5-20-8-2.

The Contractor shall train its providers in identifying and treating members with behavioral health disorders and shall train PMPs and specialists on when and how to refer members for behavioral health treatment. The Contractor shall also train providers in screening and treating individuals who have co-existing mental health and substance 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 FSSA 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 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.

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

The Contractor shall employ or contract with 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 4.0. The Contractor shall provide appropriate care management for any member at risk for inpatient psychiatric or substance use disorder hospitalization, and for members discharged from an inpatient psychiatric or substance use disorder hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization. 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 shall schedule an outpatient follow-up appointment to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge. Per 40 CFR 159.153, hospitalization means admission for treatment to a hospital, clinic, or other health care facility. Treatment as an out-patient is not considered to be hospitalization.

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. The care coordinator and/or service coordinator shall provide this notification within five (5) calendar days of the hospital admission or emergency treatment.

Documentation of care coordination and service coordination procedures, contacts, interventions, and outcomes shall be made available to FSSA upon request.

3.6.4 Behavioral Health Care Coordination

The Contractor shall ensure the coordination of physical and behavioral health care among all providers treating the member. The Contractor shall coordinate services for individuals with multiple diagnoses of mental illness, substance 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 medical data with physical and behavioral health providers and coordinate care for all members receiving both physical and behavioral health services, to the extent permitted by law and in accordance with the member's consent, when required. The Contractor shall contractually mandate that its behavioral health care providers provide member records to the Contractor upon request. 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

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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 implement mechanisms to ensure coordination among member's providers. With appropriate consent, the Contractor shall notify behavioral health providers and medical providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. This notice must be provided within five (5) calendar days of the hospital inpatient admission or emergency treatment. The Contractor shall maintain a description of strategies proposed to receive hospital notification of inpatient admissions to facilitate meeting the requirement for example through the use of incentive programs.

The Contractor shall develop additional mechanisms for facilitating communication 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 require the behavioral health provider to share clinical information directly with the member's PMP. The Contractor shall evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes.

Documentation of integration policies and procedures and outcomes data shall be made available to FSSA upon request and at minimum on a semi-annual basis. Additionally, the State is exploring implementation of new initiatives for behavioral and physical health integration for Indiana Medicaid members. The Contractor shall participate in the planning and execution of State-driven integration at the direction of FSSA.

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

3.6.5 Behavioral Health Continuity of Care

The Contractor shall utilize care coordinators 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 follow 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)

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.

In accordance with 42 CFR 457.1201(e) and 42 CFR 438.3(e)(2)(i)-(iii), the State has determined that treatment in an IMD is a medically appropriate and cost-effective substitute for the behavioral health service covered under the State Plan in other settings. Contractors may, but are not required, to use an IMD in lieu of other behavioral health services. The Contractor is prohibited from requiring an enrollee to access behavioral health services at an IMD.

The State will make monthly capitation payment to the Contractor to 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

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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 crisis 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 sixteen (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 438.6(e).

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.

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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

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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.

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

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 PASRR 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

Short-term nursing facility care is temporary medical aftercare following a surgery, injury, illness, or other medical condition that is expected to improve. Services are goal-oriented, medically necessary care that can only be provided by or under the supervision of skilled or licensed personnel and typically last several weeks or a few months depending on the severity of the condition being treated. The contractor is responsible for obtaining services for its members in a skilled nursing facility setting on a short-term basis. The contractor is responsible for ongoing management of a member's care for each admission. The contractor is responsible to start member discharge planning on the day of admission to the nursing facility. The contractor will coordinate care and work with the nursing facility to discharge members quickly and safely to their home. The contractor must work to coordinate member benefits and ensure there is no duplication of benefits when Medicare is the primary payer.

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Long-term nursing facility care is ideal for members with chronic or progressive medical conditions, such as Parkinson's disease, permanent disabilities, dementia, or a debilitating stroke. This is a permanent placement for members who will permanently reside in the nursing facility and are not expected to return home. The contractor must have processes in place to monitor all long-term nursing facility stays. Contractor must assign a service coordinator to all its members residing in a long-term care facility.

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 to Medicaid members of any age in the member's place of residence. Coverage for Home Health Services is detailed in the IHCP Home Health Services Provider Manual and can range from acute home health services to long-term and continuous services, depending on member need. Members may receive home health services in any setting in which normal life activities take place, per 42 CFR 440.70(b)(3) other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483), 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 an authorized provider pursuant to a written plan of treatment, and less expensive than any alternate modes of care. Home health services include intermittent or part-time skilled nursing care per 42 CFR 440.70(b)(1), home health aide services per 42 CFR 440.70(b)(2), and skilled therapies such as physical therapy, occupational therapy, and speech-language therapy per 42 CFR 440.70(b)(4) and 42 CFR 440.11, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and appliances suitable for use in any setting in which normal life activities take place (as defined at § 440.70(c)(1)) per 42 CFR 440.70(b)(3). For additional information, see Home Health Services provider reference module.

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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 (see also: 42 CFR 418.3).

The Contractor shall provide Hospice care to members who meet the criteria established by FSSA 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.

Caregiver Coaching will be added to the HCBS Waiver.

<u>Caregiver Coaching</u>

The purpose of Caregiver Coaching 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.

3.10 Participant-Directed Attendant Care Services (PDACS)

Self-directed Medicaid services means that participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Self-direction of services allows participants to

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have the responsibility for managing aspects of service delivery in a person-centered planning process.

Member participation in PDACS is voluntary. Members may elect to participate. in PDACS at any time, without affecting their enrollment in PathWays. 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 in PDACS;
- The benefits of self-direction; 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 pre-screening tool developed by the State. The pre-screening tool 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 member requests assistance to participate in PDACS, the Service Coordinator shall inform and support the member in 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, guardian, and/or power of attorney 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.

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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) vendor(s) in which the member has selected 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.

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 pre-screening tool, 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;

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- 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 PathWays 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.

For members electing self-direction of HCBS services, the Contractor shall allow eligible members to utilize the State's FMS vendor(s). The Contractor shall treat the State's financial management services vendor(s) and all direct service workers employed under the FMS vendor(s) as in-network providers. A member's chosen individual care providers shall not be required to enroll as IHCP providers. A member's chosen and State approved FMS vendor(s), shall enroll as an IHCP provider.

A service broker services should be made available in accordance with the Self Direction Manual. A service broker is a professional who delivers information and assistance which includes collaborating with the waiver participant to support them in:

- understanding and managing the responsibilities involved with self-direction,
- developing daily implementation of and managing the self-directed plan and budget,
- employer responsibilities such as recruiting, supervising, and training of participant-hired staff, and/or
- service documentation requirements to ensure agreement with program and Medicaid standard and risk assessment, planning and ensuring safeguards are identified and met.

The Contractor will adhere to the policies and procedures in the State's Self-Direction Manual.

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:

- 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

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b. Any additional risk associated with the member participating in PDACS that may need to be addressed in the member's service plan.

- Conduct limited criminal background history checks on attendant care workers;
- Receive, review and process timesheets;
- Resolve discrepancies regarding timesheets;
- Provide the member, the member's representative (as applicable) and the Service Coordinator with monthly reports on utilization
- 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;
- The FMS will also provide the following information and supports on an as-needed basis:
- 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;

The Service Coordinator has primary responsibility for oversight and monitoring members' utilization and management of PDACS.

The Contractor will monitor service utilization by members using PDACS. The Contractor will monitor a member's participation in PDACS to assess, 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.

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:

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- 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; or
- 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; or
- 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.

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

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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, Caregiver Coaching, or Self-Directed Attendant Care. For informal caregivers who receive the Caregiver Coaching 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. Permission 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.

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- 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 Caregiver Coaching

Pending CMS approval of the Caregiver Coaching waiver service, an Informal Caregiver Coach is a provider authorized to deliver the Caregiver Coaching 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. Caregiver Coaching 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.

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The Contractor shall have a Housing Coordinator dedicated to overseeing housing services and supports for PathWays. Additionally, the Contractor's care managers, care coordinators 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 all DME rented or purchased with Medicaid funds, except for the following:

1. Cervical collars.
2. Back supportive devices such as corsets.
3. Hernia trusses.
4. Oxygen and supplies and equipment for its delivery for nursing facility residents.
5. Parenteral infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters.

Prior authorization is required for oxygen concentrators, except when used for nursing facility residents who have been certified as needing oxygen services by a physician. All oxygen equipment and supplies, including concentrators and portable liquid oxygen equipment, require prior authorization for members in a home setting. The member's need for oxygen must be certified by a physician.

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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 an FDA-approved opioid agonist or antagonist medication-assisted treatment (MAT) medication, routine drug testing, group therapy, individual therapy, pharmacological management, follow-up examinations 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).

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Prior authorization (PA) is not required for OTP services. However, providers must maintain documentation demonstrating medical necessity, that the coverage criteria are met and the individual's length of treatment, in the member's records.

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 PathWays program per Exhibit 3A 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 PathWays program per Exhibit 3A 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 resources 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;

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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 address the safety needs of the person with disabilities and/or special needs.

All NEMT transportation providers must actively hold Indiana Motor Carrier Certification (unless exempt by law or carrier classification), secure and maintain the minimum required automobile liability insurance, meet the IHCP provider enrollment type and specialty requirements, and be actively enrolled as an IHCP Medicaid provider. Transportation providers may be subject to other state and federal statutes and regulations in regard to insurance requirements. This minimum liability amount does not excuse a provider from their requirement to continuously comply with all state and federal statutes, rules, and local ordinances governing carrier transportation. The Contractor is responsible for ensuring all initial certification and enrollment are complete prior to contracting 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.

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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 PathWays 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 at 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).

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 PathWays 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.

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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 PathWays 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 Diabetes Supplies Coverage

The Contractor shall provide diabetes testing supplies coverage for members not eligible for Medicare benefits. The Contractor shall cover diabetes testing supplies in alignment with FSSA's Preferred Diabetes Supply List (PDSL). The Contractor shall configure its claims payment system to approve the diabetes testing supplies of FSSA's contracted preferred vendors to supply blood glucose monitors, including corresponding test strips, and continuous glucose monitors, including corresponding sensors, scanners and reading devices. The Contractor shall require prior authorization for all non-preferred diabetic supplies not included on the PDSL. The Contractor shall ensure that NDCs for diabetes testing supplies are included on all claims.

3.19 Service Delivery Innovation

The Contractor must promote innovation in the PathWays 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,

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- 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 PathWays populations and, therefore, are not the responsibility of the Contractor. These services are referred to as "carved-out" services. Carved-out services, as defined by the State, include services that are carved out of managed care program coverage, meaning that they are the financial responsibility of the State to provide to managed care members via fee-for-service (FFS) Medicaid benefits. This definition also includes services that could potentially require a managed care member to be disenrolled from a managed care plan and instead be reenrolled into traditional Medicaid to obtain the FFS benefit. The State fiscal agent pays on an 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 PathWays program and the conditions under which related services are the Contractor's responsibility. The PathWays 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.

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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 PathWays 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. Excluded services are defined by the State as services that are not covered under Indiana Medicaid (see also: 405 IAC 5-29-1).

The Contractor is responsible for the member's care until the member is disenrolled from the plan unless stated otherwise. The PathWays MCE Policies and Procedures Manual describes member disenrollment in greater detail.

Listed below are the services excluded from the PathWays program.

3.21.1 Psychiatric Treatment in a State Hospital

PathWays members receiving psychiatric treatment in a state hospital will be disenrolled from the program.

3.21.2 Intermediate Care Facilities for Individuals with Intellectual Disabilities

PathWays 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. PathWays 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

The Community Integration and Habilitation Waiver is a Medicaid Home and Community Based Services waiver for children and adults with intellectual and developmental disabilities. PathWays members who become eligible for the waiver will be disenrolled from PathWays and enrolled in Traditional Medicaid.

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3.21.5 Family Supports Waiver

The Family Supports Waiver is a Medicaid Home and Community Based Services waiver for children and adults with intellectual and developmental disabilities. PathWays members who become eligible for the waiver will be disenrolled from PathWays 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 PathWays 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 PathWays 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 PathWays 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.

The Contractor shall provide continuity of care for the authorization of services as well as choice of providers for ninety (90) days. 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 ninety (90) days from the date of enrollment. 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: ninety (90) 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. MCEs must have a process to receive and transfer member information and the process must be managed by a transition coordinator. 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.

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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 PathWays 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 an amount not less than one hundred percent (100%) of the Medicaid fee-for-service rate.

The Contractor may not require an out-of-network provider to acquire a Contractor-assigned

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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 PathWays 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 PathWays 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:

- Enhance 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 PathWays 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);

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- 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; and

- 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 PathWays program per Exhibit 3A 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.

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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 PathWays 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 to ensure optimum therapeutic outcomes
- Reduce risk of adverse events
- Improve adherence
- Be furnished by pharmacists or other qualified providers.

3.27.2 General Requirements

The general requirements are based on the CMS Medicare Part D MTM program requirements as described in 42 CFR 423.153. 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. 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 PathWays, 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.

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- 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.

- Provide all MTM enrollees, at least annually, information about safe disposal of controlled prescription drugs, pursuant to 42 CFR 423.153(d)(1)(vii)(E).

- 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.

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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 twelve (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 PathWays 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 complement the Contractor's companion D-SNP Model of Care (MOC).

The Contractor shall implement a transition of care policy that is consistent with federal requirements and at least meets the State defined transition of care policy in the PathWays Policy and Procedure Manual pursuant to 42 CFR 438.62(b)(1)-(2). 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

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members, while Complex Case Management must be available to high-risk/high-need members who meet State-defined criteria (Section 4.2.2). 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 receive 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.

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 PathWays 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 PathWays 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 PathWays 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

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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. 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.

Care Coordination services shall be provided to all eligible members. 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.

For members who opt out or choose not to actively participate or are unable to be involved in their care plan, the Contractor shall actively coordinate care and services between the member's PMP, other providers, and natural supports system. The care plan will identify the problems, barriers and issues related to the individual's health care needs and identify strategies for best engaging the member in his/her own treatment.

The Contractor shall not engage in any activities that encourage members to exclude themselves from Care Coordination or Service Coordination. Furthermore, should members request to receive a lower level of Care Coordination, the Contractor shall honor this request as allowed within the parameters of the Scope of Work.

4.2.1 Care Management

Care Management is the foundational Care Coordination level of service that shall be made available to all PathWays 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.

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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 (CMHCs). 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 (CCM) includes all the services and benefits from Care Management. CCM involves the coordination of care and services with the member and between providers while navigating the systems and resources required for the member. It includes the CHAT, 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.

Complex Case Management is for members who are at risk of an acute or catastrophic episode in the future or for members with one or more of the following:

- 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
- 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%
- serious mental illness (SMI)
- substance use disorder (SUD)
- significant cognitive impairment, including Alzheimer's disease and related dementias (ADRD)

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- an unplanned inpatient stay or more than two (2) ER visits in the last ninety (90) days
- high dollar medical claims of over fifty thousand $50,000 dollars (>$50,000) in six (6) months (excludes LTSS claims)
- an NFLOC determination and are receiving LTSS in a home or community-based setting
- self-referral to the Contractor's Care Coordination program
- provider referral for the member to the Contractor's Care Coordination program
- unstable housing that may exasperate health conditions

*This is not an all-inclusive list for stratification to Complex Case Management. The Contractor is responsible for using multiple methods to identify high-risk members to help mitigate risk.

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.

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 of the members' medical and non-medical services, including functional, social, and environmental services.

Members residing in a nursing facility are excluded from the Contractor's CCM requirements unless the member specifically requests case management while in the facility.

For members who are unable or unwilling to participate in Complex Case Management, the Contractor must provide care coordination, including comprehensive assessments, determination of available benefits, and development and implementation of a care plan. The care plans for these members will focus on the individual's chronic health needs through communication with their respective PMP, other ICT providers, the Service Coordinator, and the member's natural support system.

The goals of CCM include avoidance of unnecessary ER visits and inpatient hospitalizations and increased use of preventive health care.

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.

Refer to the Care Coordination Program Manual for more information on Complex Case Management.

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4.2.3 Complex Case Management and Service Coordination

In addition to Complex Case Management, members who are determined NFLOC and receive HCBS 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. If the member is receiving Care Coordination, 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. For members who opt out or choose not to actively participate or are unable to be involved in Complex Case Management, the Contractor shall actively coordinate care and services between the member's PMP, other providers, and natural supports system.

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 on the State "Manuals" page (https://www.in.gov/medicaid/partners/medicaid-partners/managed-care-health-plans/mce-secure-landing-page/mce-manuals/). 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;

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- 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.

Dually enrolled PathWays members are excluded from Indiana's RCP program and monitored through Medicare. Section 1860D-4(c)(5)(A) of the Social Security Act requires Medicare Part D sponsors to establish drug management programs (DMPs) for beneficiaries who are at risk for misuse or abuse of frequently abused drugs (FADs).

4.3 MLTSS and Medicare Care Coordination Alignment

The PathWays 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 PathWays;
- "Dual Eligible – Aligned" which includes dually eligible members who are enrolled in both the Contractor's PathWays program and the Contractor's exclusively aligned companion D-SNP; and
- "Dual Eligible – Unaligned" which includes dually eligible members who are enrolled in the Contractor's PathWays 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.

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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. For aligned D-SNP members see Section 4.17.2 ICT Participant Roles and Responsibilities for additional requirements. For the "Dual Eligible – Aligned" category, 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 PathWays program 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". For aligned D-SNP members see Section 4.17.2 ICT Participant Roles and Responsibilities for additional requirements. Coordination of discharge planning 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 PathWays 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.

For members in "Dual Eligible – Aligned", the Contractor shall incorporate the aligned DSNP health risk assessment (HRA), in lieu of the required health needs screening. The Contractor shall ensure the aligned DSNP is providing care management and shares completed assessments and care plans. It is the expectation that the Contractor will use the appropriate aligned DSNP resources to meet certain components outlined in the Contract.

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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 PathWays population (i.e., what sets them apart from the overall PathWays 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

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- Polypharmacy in need of medication management
- Enteral and parenteral nutrition
- Previously incarcerated
- Adult protective services
- Inpatient Psychiatric Care
- Intellectual and Developmental Disabilities
- Serious 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

In accordance with 42 CFR 438.208(b)(3), the Contractor shall conduct an initial screening or assessment 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. Individuals receiving NFLOC HCBS in the community are not required to have a separate screening. The Contractor shall complete the full State-developed Comprehensive Health Assessment Tool (CHAT), in lieu of the initial screening. The CHAT completion must be completed within thirty (30) days of the effective date of enrollment. The Contractor must make at least three subsequent attempts on different days to conduct an initial screening or assessment 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 or CHAT, 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 or assessment shall also identify members who have complex or serious medical conditions that require an expedited appointment with an appropriate provider. The initial screening or

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assessment 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 or assessment 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 or assessment shall:

- Utilize the FSSA Health Needs Screening tool or CHAT;
- 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 with information on how members can opt back in at any time.

4.6 Comprehensive Health Assessment

In accordance with 42 CFR 438.208(b)(3) and 42 CFR 438.208(c)(1)-(2), the Contractor shall conduct a Comprehensive Health Assessment using a State-developed Comprehensive Health Assessment Tool (CHAT) of all members to identify the appropriate services, programs, and Care Coordination level of service for the member. The CHAT will be all-inclusive and identify the clinical, psychosocial, functional and financial needs of the member to ensure appropriate referrals to the Contractor's programs and community-based organizations. The CHAT shall be completed according to the timeframes below, either by phone or face to face, and will be used to develop and implement an ICP to meet the member's needs.

The State-developed CHAT is a functional assessment based on the interRAI suite of assessment instruments. The Contractor will administer the Brief CHAT or full CHAT depending on the member population outlined below. See Sections 4.8 and 4.8.1 for LTSS assessment requirements.

- Brief CHAT – completed for members who do not meet NFLOC or do meet NFLOC residing in a nursing facility. An initial Brief CHAT is completed within ninety (90) calendar days of the effective date of enrollment. The Brief CHAT can

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be done onsite or telephonically. The Brief CHAT is completed annually or anytime there is a significant change in status.

- Full CHAT – completed for members who meet NFLOC and are receiving HCBS. A CHAT is completed within 30 calendar days of the effective date of enrollment. The CHAT is done onsite with the member and the member's team. The CHAT is completed annually thereafter and anytime there is a significant change in status.

- Level of Care (LOC) – The full CHAT is used to determine annual NFLOC for HCBS members and every thirty-six (36) months for individuals residing in a nursing facility. A full CHAT is also completed anytime a member is referred for LTSS to assess NFLOC.

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. 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 CHAT may be augmented with condition specific and/or Contractor specific elements upon review and approval by FSSA. The CHAT includes 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 an NFLOC determination and redetermination. 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

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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 on an as-needed basis, including upon reassessment of functional need, when the member's circumstances or needs change significantly, or at the request of the

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member, but no less often than annually per 42 CFR 441.301(c)(3). With the member's consent, their family members and informal caregivers can participate in reviewing and updating their Individualized Care Plans. For members who qualify for Service Coordination and receive LTSS in the home or community, Service Coordinator shall 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 Contractor shall conduct the full CHAT onsite every thirty-six (36) months and submit the results to the entity or entities designated by the State for an updated NFLOC. The Contractor's 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 areas 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.

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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 HCBS 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.

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- 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

Members residing in nursing facilities will have an assigned Service Coordinator. The Service Coordinator will work as part of the member's ICT and as a resource to the nursing facility staff. The Service Coordinator is responsible for conducting a LOC assessment every thirty-six (36) months and submitting to the State entity for LOC determination. The Service Coordinator is expected to coordinate with the nursing facility and the member to gather the information needed to complete the LOC assessment. Annually, the Contractor is responsible for completing the Brief CHAT when the member does not need a LOC assessment. As part of onsite assessment and 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. Members residing in a nursing facility are not required to stratify into care or complex care management, unless the member or provider asks to be enrolled in one of these programs. A Care Coordinator is assigned to all members residing in a nursing facility, but the Service Coordinator should be the main point of contact. The Service Coordinator is responsible for involving the Care Coordinator when clinical support is needed. The nursing facility is responsible for coordinating the member's care and the Service Coordinator should participate as a supporting role to the nursing facility.

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On a quarterly basis the Service Coordinator is responsible for completing the loneliness assessment and the Person Centered Monitoring Tool. If appropriate the Service Coordinator should also complete an informal caregiver assessment, with the consent of the member.

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, Caregiver Coaching, 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 Caregiver Coaching 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

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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 Caregiver Coaching 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 State approved curriculum to develop a strengths-based, person-centered care plan development process. Current State approved curriculum is "Person Centered Thinking" through The Learning Community for Person Centered Practices.

"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 coordinators 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

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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, detailing how the results of the initial

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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.

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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. This includes care plans for members needing Complex Case Management but who are unable or unwilling to actively engage with the Contractor. See 4.2.2 for more information.

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

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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.

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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 CFR 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;

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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; and

12. Referral to all training, education and resources for informal caregivers as required in the Informal Caregiver Supports and 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 CFR 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; and

- The individual and/or entity responsible for monitoring the plan

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For each member receiving LTSS services, the Contactor shall assign a Service Coordinator. The Contractor must provide the member with contact information for their designated Service Coordinator. At a minimum, contact information shall be included on the member's person-centered service plan and their Notices of Action. Contact information includes the Service Coordinator's full name, email address, and direct phone number.

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), 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 members' 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

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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. 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 and members' designated representatives (if applicable) 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 7.8.5 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

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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(s) 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 it is determined that additional HCBS are needed or that HCBS services should be decreased.

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

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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 30 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

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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.

For aligned D-SNP members see Section 4.17.2 ICT Participant Roles and Responsibilities for additional requirements.

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

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known, etc.). All members in Complex Case Management must receive materials no less than monthly.

For Complex Case Management members who are not receiving Service Coordination (non-NFLOC), the member's Care Coordinator shall meet with the member in-person at least once per year to conduct the Brief CHAT and review and update the member's ICP. 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 shall be contacted by their Care Coordinator monthly either face to face 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. When applicable, 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 30 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. At least two of these face-to-face contacts per year will be in the member's home setting. 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. HCBS waiver members cannot opt out of the minimum contacts requirements.

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. The 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

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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.

For members who have the ability and desire to discharge to HCBS, the 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.

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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

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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 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 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

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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.

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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 an 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

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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 agrees with the transfer

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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 Section 2.4.

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 PathWays 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.

For aligned D-SNP members see Section 4.17.2 ICT Participant Roles and Responsibilities for additional requirements.

4.13.2 Person Centered Practices Training

All Care and Service Coordinators must complete specialized training in person-centered practices through a State approved curriculum. Current State approved curriculum is "Person Centered Thinking" through The Learning Community for Person Centered Practices. Care and Service Coordinators must complete training within ninety (90) days of hire. Care and Service Coordinators must complete this required training prior to serving PathWays members.

The Contractor must employ staff who are certified through a State approved train-the-trainer program or subcontract with an approved vendor to be able to provide training to the Contractor's Care Coordinator and Service Coordinator staff on an ongoing basis throughout the Contract period.

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4.13.3 Care Coordinator Training Requirements

In addition to the required 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, care plan development and updates, and population specific training relevant to the populations enrolled in the PathWays program; 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 PathWays 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

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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; and
- 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.

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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 Person-Centered Practices Training

All Service Coordinators must complete "Person-Centered Thinking Training" through a State approved curriculum for Person-Centered Practices or a State approved certified trainer within ninety (90) days of their hire date, or if already employed by Contractor at the Contract start date, then within 90 days of beginning work as a Service Coordinator under this Contract. A Service Coordinator who has not yet completed the training must have each service plan reviewed and signed off on prior to the plan's effective date by a Service Coordinator Supervisor who has completed the training. All Service Coordinators must complete this training on an annual basis for all future years of employment.

4.14.3 Service Coordinator Training Requirements

In addition to the required 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, care plan development and updates, and population specific training relevant to the populations enrolled in the PathWays program; 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;

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- 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 PathWays 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;

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- 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 may subcontract for Service Coordination with external care management entities who are approved to provide waiver case management services. The Contractor's Care Coordination Program Plan shall describe the development of these relationships, methods for communication, and accountability, quality oversight, and performance standards.

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. For members who are assigned to Care Management according to the criteria in Section 4.2.1, the Contractor shall use a variety of tools to assess the Care Coordinator-to-member ratio to ensure health outcomes. The Contractor must include their process for determining case load ratios in their annual Care Coordination Plan submission.

When appropriate, the Contractor may assign 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. Individuals who serve as both a care coordinator and service coordinator must follow the average Service Coordinator-to-member staffing ratios found in Section 4.16.

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. The Contractor shall analyze the needs of their member population to determine the need for added specialty support.

The average Service Coordinator-to-member staffing ratio shall be no more than 1:67 for HCBS members. It is the responsibility of the Contractor to ensure that minimum member contact and assessment, reassessment, and service planning turnaround times are enforced. The Contractor shall determine caseload ratios for Service Coordinators based on the particular needs of their member population.

4.16.1 Service Coordinator for NF Residents

The Contractor shall assign or designate one Service Coordinator to each nursing facility within the Contractor's network to serve institutional LTSS members and

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support ongoing collaboration with facilities and facility-based resources. The Service Coordinator shall consult with the member's Care Coordinator when needed for health and wellness concerns, or when requested by the member, the member's natural supports, the member's provider, or the ICT.

4.17 Interdisciplinary Care Team (ICT)

Under PathWays, 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 PathWays 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 PathWays 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 PathWays members who are assigned to Complex Case Management.

4.17.1 ICT Participants

For PathWays 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

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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 PathWays 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. The D-SNP Care Manager will serve as the member's single point of coordination if and when the D-SNP has assigned a designated Care Manager for longitudinal care coordination to the aligned D-SNP member (i.e., PathWays Waiver participants and members having a diagnosis of dementia as required under the current SMAC, and others according to the D-SNP's specific MOC and stratification processes as approved by CMS). For aligned D-SNP members not having a designated longitudinal D-SNP Care Manager, the Contractor's designated Care Coordinator will serve as the single point of coordination. At all times, the Contractor's Care Coordinator will partner with the aligned D-SNP staff to provide care coordination such that the aligned D-SNP member's experience will be as close as possible to the care coordination experience of a non-dual Medicaid only PathWays member.

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.

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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, recorded attendance of all ICT members, 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. The Contractor will provide authorized OMPP auditors, who are agreed upon by OMPP and the Contractor, access to the electronic medical record system where care and service coordination activities are documented and tracked. OMPP access will be in compliance with MCE privacy practices and are solely for the purposes of auditing care and service coordination activities.

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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 provide Care Coordination and/or Service Coordination for members covered under this Contract including subcontracts with PathWays waiver care management entities that were approved prior to PathWays go-live.

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 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;

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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)

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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 home health services, 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

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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 438.104. 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.

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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. Cold-call marketing is defined at 42 CFR 438.104 and includes any unsolicited personal contact by the Contractor with a potential Medicaid member;

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 PathWays program by the State of Indiana.

5.2 Member Enrollment and Contractor Selection

PathWays applicants have an opportunity to select an MCE. MCEs are expected to conduct outreach and education to inform individuals of the PathWays Program and their product. The Enrollment Broker is available to assist members in choosing an MCE. Applicants who do not select an MCE will be assigned to an MCE according to the State's assignment methodology. The Contractor's companion D-SNP must be exclusively aligned with its PathWays Medicaid plan and will only be allowed to enroll dual eligible members who are also enrolled in its Pathways Medicaid plan. Members enrolled in the Contractor's PathWays

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Medicaid plan who later become Medicare-eligible for the first time will be default enrolled into the Contractor's companion D-SNP. Where applicable, the Contractor, through their D-SNP, shall proactively identify members before they become 60 years of age and assist them in transitioning to the PathWays program and the PathWays Waiver.

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. 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 that lose Medicaid eligibility in the PathWays program for a period of two (2) months or less shall be automatically reenrolled with the Contractor in accordance with 42 CFR 438.56(g).

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, PathWays 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 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, PathWays 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.

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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 5.7.2, and the member's ID card. Refer to the PathWays MCE Policies and Procedures Manual and Section 5.6 for specific information regarding the PathWays 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 ensure 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 PathWays 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.

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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, gynecologists, 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 5.2.2) 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 438.56(b)(2), the Contractor may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs, adverse change in a member's health care status, diminished mental capacity, or because of uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the member or other members). A member's health care utilization patterns may not serve as the basis for disenrollment from the Contractor.

In accordance with 42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); and 42 CFR 438.56(c)(2)(i)-(iii), members have the right to disenroll from the Contractor:

- For just cause at any time.

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- Without cause within ninety (90) days after initial enrollment or during the ninety (90) days following notification of enrollment, whichever is later.

- Without cause at least once every twelve (12) months.

- Without cause when a Contractor repeatedly fails to meet substantive requirements in sections 1903(m) or section 1932(e)(2)(B)(ii) of the Social Security Act and 42 CFR 438.56(b)-(d).

- Without cause upon reenrollment if a temporary loss of enrollment has caused the enrollee to miss the annual disenrollment period.

Additional member rights to disenroll from Indiana PathWays for Aging include:

- During the Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year.

- 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.

In accordance with 42 CFR 438.56(d)(2)(i)-(v), members may request disenrollment if the:

- Member moves out of the service area.

- Contractor does not cover the service the enrollee seeks because of moral or religious objections.

- Member needs related services to be performed at the same time and not all related services are available within the provider network. The member's provider must determine that receiving the services separate would subject the member to unnecessary risk.

- Contractor's provider status changes from in-network to out-of-network and causes the member to have to change their residential, institutional, or employment supports provider, and, as a result, the member would experience a disruption in their residence or employment. This requirement is specific to MLTSS programs.

- Member experiences poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the member's care needs.

Members must file a grievance with their MCE before a determination will be made upon their just cause request for disenrollment and the Contractor must ensure it reviews the grievance in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment or the Contractor refers the request to the broker per 42 CFR 438.56(d)(5)(ii), 42 CFR 438.56(e)(1) and 42 CFR 438.228(a). Per 42 CFR 438.56(e)(2), if a disenrollment determination is not made within the specified timeframes (i.e., the first day of the second month following the month in which the enrollee requests disenrollment or the Contractor refers the request to the broker), the disenrollment is considered approved for the effective date that would have been established had the determination been made in the specified timeframe.

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The Contractor shall notify FSSA in the manner outlined in the PathWays 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 PathWays 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 PathWays 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 PathWays 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 PathWays 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 PathWays, so that members may call one number to answer questions about all the IHCP programs the Contractor is contracted as an MCE for. The same helpline must also service members of the Contractor's exclusively aligned D-SNP as required in the aligned D-SNP's SMAC. 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:

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- 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 PathWays 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 coordinator or service coordinator. The Contractor shall ensure the care coordinator has access to all information necessary to resolve the member's issues. Any messages left with care coordinators 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 PathWays 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;

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- 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;
- Health crises, including but not limited to suicidal callers; and
- Medicare coverage and Indiana PathWays for Aging Dual Care.

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 PathWays, PMP issues, benefits, Contractor policies, etc.

- The Contractor must maintain sufficient equipment and staff to ensure member call center metrics as published in the MCE Reporting Manual.

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 PathWays members seeking services from hospital Emergency departments.

5.3.2 Electronic Communications

The Contractor shall identify how they intend to leverage technology in their member outreach strategies.

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As required by 42 CFR 438.10(c)(6), if the Contractor chooses to provide any required information electronically to members:

- The information must be in a format that is readily accessible.
- The information must be placed in a location on the Contractor's website that is prominent and readily accessible.
- The information must be provided in an electronic form which can be electronically retained and printed.
- The information must be consistent with content and language requirements.
- The Contractor must notify the member that the information is available in paper form without charge upon request.
- The Contractor must provide, upon request, information in paper form within five (5) business days.

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 one business day. If the Contractor is unable to answer or resolve the member's question or concern within one business day, the inquiry becomes a grievance. See Sections 5.14.2 and 5.14.3.

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 comply with the information requirements at 42 CFR 438.10, including notifying all members of their right to request and obtain information. 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 (refer to Section 5.7.2).

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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.

All member and provider facing documents must reference the member's Medicaid ID number. No other number, including the Contractor's internal system tracking number, may be included and/or referenced on member documents. This does not apply to members in an aligned D-SNP. Member and provider communications may have the required Medicaid ID number and also include the D-SNP health plan ID number.

All enrollment notices, informational and instructional materials must be provided in a manner and format that is easily understood. This means written materials shall not exceed a fifth-grade reading level and shall 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; information about the potential enrollee's/member's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee/member based on their specific circumstance; which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program (for mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the member must also be specified; any cost-sharing that will be imposed by the Contractor consistent with those set forth in the State plan; and the Contractor's responsibilities for coordination of member care.

The State shall provide information on PathWays 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.

As required by 42 CFR 438.10(d)(3), the Contractor shall take into consideration the special needs of the member or potential enrollee with disabilities or limited English proficiency and make auxiliary aids available upon request at no cost. The Contractor shall make written information available in the language requested by the member. See Section 5.12. 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 readily provided to members in any such prevalent languages identified by the Contractor. Other non-prevalent languages shall be provided to the member following the requirements outlined in Section 5.12.

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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 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 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, 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.

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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 determinants 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 PathWays program. This includes publicizing methods by which members can ask questions regarding the PathWays 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 PathWays 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

6 The member's name (First, Last and Middle Initial)

7 Bank Identification Number (BIN), Processor Control Number (PCN), and group number identifiers assigned by the PBM that are unique to and exclusively used for the IHCP as required by 42 CFR 438.3(s)

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 provide 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.

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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 PathWays 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

The Contractor shall develop a member handbook for its members and disseminate it as required under 42 CFR 438.10(g)(3)(i)-(iv). Within five (5) calendar days of a new member's full enrollment with the Contractor in accordance with Section 5.8, the Contractor must provide 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 Contractor is required to provide members notice of any significant change, as defined by the State, in the information specified in the member handbook at least 30 days before the intended effective date of the change per 42 CFR 438.10(g)(4). 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 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).

Per 42 CFR 438.10(g)(3)(i)-(iv), member handbook information is considered to be provided to the member if the Contractor:

- Mails a printed copy of the information to the member's mailing address;
- Provides the information by email after obtaining the member's agreement to receive the information by email;
- Posts the information on its website and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; OR
- Provides the information by any other method that can reasonably be expected to result in the member receiving that information.

The PathWays member handbook shall include the following:

1. Contractor's contact information (address, telephone number, TDD number, website address);
2. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members;

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3. The amount, duration and scope of services and benefits available under the Contract in sufficient details to ensure that members understand of the services to which they are entitled, including, but not limited to the differences between the benefit options;

4. The procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and other benefits not furnished by the members primary care provider;

5. Contractor's office hours and days, including the availability of a 24-hour Nurse Call Line;

6. Information on accessing transportation including how it is provided for any carved-out benefits per 42 CFR 438.10(g)(2)(i);

7. 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;

8. 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;

9. The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(g)(2)(v), such as what constitutes an emergency;

10. The post-stabilization care services rules set forth in 42 CFR 422.113(c);

11. The extent to which, and how, urgent care services are provided;

12. The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCE cannot require an enrollee obtain a referral before choosing a family planning provider.

13. Applicable policy on referrals for specialty care and other benefits not provided by the member's PMP, as applicable;

14. Information on available Home and Community Based Services (HCBS) benefits and education on how to access HCBS;

15. Information on long-term services and supports and education on how to access long-term services and supports;

16. Information about the availability of pharmacy services and how to access pharmacy services;

17. Information about all relevant or applicable State ombudsman programs.

18. 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;

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19. Information about the member's right to choose between nursing facility and HCBS.

20. A description of the Care Coordinator and Service Coordinator role and responsibilities

21. Responsibilities of members;

22. Special benefit provisions (for example, co-payments, deductibles, limits or rejections of claims) that may apply to services obtained outside the Contractor's network;

23. Information on how and where to access any benefits provided by the State, including any applicable cost cost-sharing policies per 42 CFR 438.10(g)(2)(ii) and 42 CFR 438.10(g)(viii);

24. Procedures for obtaining out-of-network services;

25. Standards and expectations to receive preventive health services;

26. Policy on referrals to specialty care;

27. Procedures for notifying members affected by termination or change in any benefits, services or service delivery sites including access to the Contractor's transition of care policy and how to access continued services upon transition per 42 CFR 438.62;

28. Procedures for appealing decisions adversely affecting members' coverage, benefits or relationship with the Contractor;

29. 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;

30. Procedures for selecting and changing PMPs;

31. 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 or immediate sanctions levied against the Contractor by the State per 42 CFR 438.56(c)(2)(iv);
    g. Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;

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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 7.8.8;
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 State or its designee to constitute poor quality of health care coverage.

32. 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 are required to exhaust the MCE's internal grievance and appeals process before requesting an MCE change due to poor quality of care;
    c. Members may submit requests to change MCEs to the Enrollment Broker verbally or in writing, after exhausting the MCE's internal grievance and appeals process;
    d. 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; and
    e. 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.

33. Procedures for making complaints and recommending changes in policies and services;

34. 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.

35. 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.

36. Information about advance directives;

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

38. 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;

39. 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.

40. Information on Medicare eligibility and when to enroll;

41. Statement that Contractor will provide information on the structure and operation of the health plan at the member's request;

42. 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;

43. How to report fraud or abuse; and

44. Availability and how to access oral interpretation for any language, written translation that is available in prevalent languages, and auxiliary aids and services upon request at no cost for enrollees with disabilities per 42 CFR 438.10(d)(5).

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 including, but not limited, to Indiana PathWays for Aging Dual Care. 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;

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- 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 members' 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 PathWays information;
- Per 42 CFR 438.10(i), information on pharmacy locations and preferred drug lists applicable to each program and benefit package in a machine-readable file and format as specified by the Secretary per 42 CFR 438.10(i)(3) and 42 CFR 457.1207;
- 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 Assessment and Performance Improvement Program Description Summary Report;
- Information on behavioral health covered services and resources.

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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. The Contractor's 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 must 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.

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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 2A 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 member website within three (3) business days of distribution.

Per 42 CFR 438.10(c)(4)(ii), the Contractor is required to use State developed enrollee notices when notified by FSSA.

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;
- Helping the member obtain required documentation and collateral verification needed to process the application; and
- Refer the member with any eligibility related questions to the DFR.

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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 supporting fraudulent activity in association with helping the member complete the redetermination process;
- Signing the member's redetermination form; or
- Completing or sending 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(a)(1) and Section 1932(b)(3)(A) of the Social Security Act, which requires that 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(a)(2) and Section 1932(b)(3)(B)(i) of the Social Security Act. 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:

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

1. The right to receive information on the managed care program and plan in which the member is enrolled per 42 CFR 438.100(a)(1) and 42 CFR 438.100(b)(2)(i)

2. The right to receive information in accordance with 42 CFR 438.10

3. The right to be treated with respect and with due consideration for the member's dignity and privacy in accordance with 42 CFR 438.100(a)(1) and 42 CFR 438.100(b)(2)(ii);

4. 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 accordance with 42 CFR 438.3(j)(1), 42 CFR 438.100(a)(1) and 42 CFR 438.100(b)(2)(iii);

5. The right to participate in decisions regarding the member's health care, including the right to refuse treatment;

6. 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 with 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(v);

7. 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 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(vi) and 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;

8. The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210, which relates to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services;

9. 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); and

10. 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(d) and 42 CFR 438.100(a)(2). 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 must not discriminate against a member that chooses to exercise their rights in accordance with 42 CFR.100(a)(1) and 42 CFR 438.100(c).

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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, audio recordings, languages other than English and verbal explanation of written materials. When a member has requested materials in a preferred alternative format, this shall be documented in the member's record. The Contractor shall supply future materials in the requested and preferred format to the member. The Contractor may review with the member and document the specific material type the member wishes to receive in a specific format versus other formats. For example, a member may wish to receive certain materials in braille and other materials in audio recordings.

Unless a member specifically states their alternative format request is a one-time request, the Contractor shall consider the request an ongoing request and supply all future materials in the preferred format to the member.

For first-time or one-time requests from a member, the Contractor shall mail the alternative 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 7.8.8 for additional information.

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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.

As required by 42 CFR 438.10(f)(1), 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 place per 42 CFR 438.10(f)(3) and 42 CFR 438.3(i).

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.

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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 except Long Term Care Ombudsmen is required by law to report cases of suspected neglect, battery or exploitation of an endangered adult to an APS unit or law enforcement. Long Term Care Ombudsmen are exempt from mandatory reporting and are prohibited by the Older Americans Act (Section 712(d)) from reporting of resident-identifying information without the resident's consent. 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 ANE 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

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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 (LTC) Ombudsman Program, and Member Support Services

For members for whom APS, an LTC Ombudsman, or Member Support Services contractor may need to be involved, the Contractor shall involve the entity in the following capacities with member consent:

- The Contractor will, as appropriate, invite APS, an LTC Ombudsman, or the 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 APS, an LTC Ombudsman, or Member Support Services contractor to participate on the interdisciplinary team to the extent of making recommendations as necessary to fulfill their respective responsibilities; and
- The Contractor will designate a staff person to serve as a member advocate and liaison between APS, an LTC Ombudsman, or Member Support Services contractor, and the member to assist in developing service options for the Contractor's members or potential members.

Information about APS is available at https://www.in.gov/fssa/da/adult-protective-services/. Information about the Long-Term Care Ombudsman Program is available at https://in.gov/ombudsman/long-term-care-ombudsman.

5.13.4 ANE Examination and Treatment Services by Providers

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 must ensure that members are immediately separated from an alleged abuser. This transition must uphold continuity of care and connect the individual with appropriate providers and other services in their community. The MCE will consult with human service agencies, as needed, to identify appropriate providers. The Contractor must then follow up to ensure that member needs are addressed on an ongoing basis. Follow-up on the success of an intervention must

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be completed within one week and reported to OMPP. All follow-up activities and referrals must be documented in the Contractor's tracking system.

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 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, Long-Term Care (LTC) Ombudsman, and Member Support Services programs through regular meetings and written policies.

5.14 Member Inquiries, Grievances & Appeals

In compliance with 42 CFR 438.402(c)(1) and 42 CFR 438.408, the Contractor shall allow members to file appeals, grievances, and State fair hearing requests (after receiving notice that an adverse benefit determination is upheld). The Contractor shall allow providers, or authorized representatives, acting on behalf of the member and with the member's written consent, to request an appeal, file a grievance, or request a State fair hearing request per 42 CFR 438.402(c)(1) and 42 CFR 438.408. The Contractor cannot require providers and/or members to use a specific form to submit an appeal.

The Contractor shall have a grievance and appeals system in place in accordance with 42 CFR 438.402(a) and 42 CFR 438.228(a) and establish written policies and procedures governing the process and resolution of inquiries, grievances and appeals. At a minimum, the grievance system must include a grievance process, a single-level 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). As required in the D-SNP's SMAC, the Contractor shall operate unified

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appeals and grievance processes with their companion D-SNP plan that adheres to CMS requirements outlined under 42 CFR 422.629-42 CFR 422.634, 42 CFR 438.210, 42 CFR 438.400 and 42 CFR 438.402.

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. A grievance is a complaint about the way a member's health plan is giving care. For example, a member may file a grievance if the member has a problem calling the plan or if the member is unhappy with the way a staff person at the plan has behaved toward them. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see appeal).

The term *appeal*, per 42 CFR 438.400(b), is defined as a request for a review of an action. An appeal is a special kind of complaint a member may make if they disagree with a decision to deny a request for health care services or payment for services they've already received. A member may also make a complaint if they disagree with a decision to stop services that they are receiving. For example, a member may ask for an appeal if Medicare doesn't pay for an item or service they think they should be able to get. There is a specific process that a member's health plan must use when they ask for an appeal.

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.

In accordance with 42 CFR 438.10(c), 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(b) and 42 CFR 438.402(b)-(c) and must include:

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- 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 per 42 CFR 438.406(b)(6).
- In accordance with 42 CFR 438.406(b)(5), 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 per 42 CFR 438.404(b)(4).
- 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 per 42 CFR 438.406(b)(4) and 42 CFR 438.408(b).
- 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

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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 in accordance with 42 CFR 438.406(b)(1) and 42 CFR 438.228(a).

- 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 in accordance with 42 CFR 438.406(a) and 42 CFR 438.228(a). 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 shall ensure that the individual rendering the decision on grievances and appeals were not involved in previous levels of review or decision-making, or were subordinates of any individual who was involved in a previous level of review or decision-making per 42 CFR 438.406(b)(2)(i), and in accordance with 42 CFR 438.406(b)(2)(ii)(A)-(C), are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following:

    - 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.

- In accordance with 42 CFR 438.408 and 42 CFR 438.402(c)(1)(i)(A), if the Contractor fails to adhere to notice and timing requirements, the member is deemed to have exhausted the Contractor's appeals process and the enrollee may initiate a State fair hearing.

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.

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5.14.3 Grievance Processing Requirements

In accordance with 42 CFR 438.402(c)(2)(i) and 42 CFR 438.402(c)(3)(i), members must be allowed to file grievances orally or in writing at any time. Members may file a grievance regarding any matter other than those described in the definition of an adverse benefit determination as described in Section 5.14.4.

The Contractor must acknowledge receipt of each grievance within three (3) business days. In accordance with 42 CFR 438.408(a) and 42 CFR 438.408(b)(1) 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 the enrollee requests the extension or the Contractor shows there is need for additional information and the delay is in the member's interest (upon State request) as required by 42 CFR 438.408(c)(1) and 438.408(b)(1). In accordance with 42 CFR 438.408(c)(2) and 42 CFR 438.408(b)(1), 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 per 42 CFR 438.410(c), 42 CFR 438.408(b)(2) and 42 CFR 438.408(c)(2). 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 notice shall be in a format and language that meets notifications standards per 42 CFR 438.408(d)(1) and 42 CFR 438.10. 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 per 42 CFR 438.402(c)(2)(ii). In accordance with 42 CFR 438.402, a provider, acting on behalf of the member, and with the

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member's written consent, may file an appeal. The Contractor cannot require providers and/or members to use a specific form to submit an appeal. In accordance with 42 CFR 438.402(c)(1)(ii), and 42 CFR 438.402(c)(3)(ii), members, the provider, or authorized representative shall be allowed to request an appeal or file a grievance orally or in writing.

In accordance with 42 CFR 438.406 (b)(3), 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 per 42 CFR 438.408(a) and 42 CFR 438.408(b)(2). This timeframe may be extended up to fourteen (14) calendar days if the member requests the extension, or if the Contractor shows that there is need for additional information and that delay is in the member's interest (upon State request), pursuant to 42 CFR 438.408(c)(1) and 42 CFR 438.408(b)(2). In accordance with 42 CFR 438.408(c)(2) and 42 CFR 438.408(b), if the timeframe is extended, for any extension not requested by the member, the Contractor must make reasonable efforts to give the member prompt oral notice of the delay and give the member written notice, within two (2) calendar days, and include the reason for the decision and inform the member of their right to file a grievance if he or she disagrees with that decision of the reason for the delay.

In accordance with 42 CFR 438.410(a), 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. In accordance with 42 CFR 438.408(a) and 42 CFR 438.408(b)(3), the Contractor must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and shall dispose of expedited appeals within forty-eight (48) hours after the Contractor receives notice of the appeal unless this timeframe is extended pursuant to 42 CFR 438.408(c). 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 compliance with 42 CFR 438.408(b)-(c), the Contractor shall provide the member or representative, the member's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions in compliance with Indiana law and no longer than thirty (30) calendar days from the day the Contractor receives the appeal. This time period is reduced to 72 hours from the day the Contractor receives an expedited appeal.

In accordance with 42 CFR 438.408(d)(2)(ii), written notice of appeal disposition must be provided to the member and, where appropriate, the provider and for notice of an expedited resolution, the Contractor must also make reasonable efforts, including a phone call to the member, to provide oral notice. 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. In accordance with 42 CFR 438.408(d)(2)(i), 42 CFR 438.10, and 42 CFR 438.408(e)(1)-(2), the written notice of the resolution

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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, IC 27-8-29-12 and 438.402(c)(1)(i)(B), 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. The member may request a State fair hearing within one hundred and twenty (120) calendar days from the date of the Contractor's decision. 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 per 42 CFR 438.406(b)(6). 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. Pursuant to 405 IAC 1.1-3-1, if the member is not satisfied with the final action after agency review, the member may file a petition for judicial review in accordance with IC 4-21.5-5. The Contractor will be subject to the contract compliance remedies (set forth in Exhibit 2A Contract Compliance and Pay for Outcomes) for failing to provide a timely and satisfactory

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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
100 N. Senate Ave., Room N802
Indianapolis, IN 46204
Fax: 317-232-4412
Email: fssa.appeals@oalp.in.gov

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(a), 42 CFR 438.420(b), and 42 CFR 438.402(c)(2)(ii). The Contractor must continue the member's benefits if:

- The member or provider files the request for an appeal within sixty (60) days following the date on the adverse benefit determination notice. The member or provider files the request for continuation of benefits within ten (10) calendar days of the Contractor mailing the notice or the intended effective date of the proposed adverse benefit determination, 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, per 42 CFR 438.420(c) and 438.408(d)(2), the benefits must be continued until one of the following occurs:

- The member withdraws the request for appeal;
- The member does not request a State fair hearing and continuation of benefits within ten (10) calendar days from the date the Contractor sends the notice of an adverse appeal resolution; or
- A State fair hearing office issues a hearing decision adverse to the enrollee; or

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- 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(b) and 42 CFR 438.420(d). 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

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- 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 PathWays program. 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 for 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

In accordance with 42 CFR 438.206(c)(2), the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members,

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including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. Per 42 CFR 438.206, 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 culturally competent services. Furthermore, the Contractor will ensure all services are delivered through a health equity lens. The Contractor shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Medicaid-insured individuals and from providers of direct services which are intended to reduce adverse health outcomes among Medicaid insured individuals, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts.

The Contractor will utilize Community Health Workers as part of broader community health integration initiatives and promotion of culturally competent care. The Contractor shall submit an annual health equity plan for FSSA approval which incorporates the U.S. Department of Health and Human Services 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/clas/standards.

The plan shall include at a minimum:

- How the health equity officer and support staff engage with member and organization advisory groups to ensure members can participate in program improvement planning and related activities.

- 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.

- 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, 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.

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- 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 by January 31 each year. 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 Contractor 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 physically and digitally accessible, following the Americans with Disabilities Act (ADA) and Section 508 of the Rehabilitation Act (Section 508) and that all subcontractors are culturally competent.

5.17 Advance Directive Information

The Contractor shall comply with the requirements of 42 CFR 422.128 and 42 CFR 489.102(a), 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.

The Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive per 42 CFR 438.3(j)(1)-(2), 42 CFR 422.128(b)(1)(ii)(F) and 42 CFR 489.102(a)(3).

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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. Per 42 CFR 438.2, a network provider is any provider, group of providers, or entity that has a network provider agreement with the Contractor, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the Contract with the Contractor. A network provider is not a subcontractor by virtue of the network provider agreement.

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 42 CFR 438.608(b), 42 CFR 455.100-106, 42 CFR 455.400-470 and FSSA. Per IC 27-13-1-24, a participating provider means a provider who, under an express or implied contract with: (1) the health maintenance organization; or (2) a contractor of the health maintenance organization or any subcontractor of a contractor of the health maintenance organization; has agreed to provide health care services to enrollees with an expectation of directly or indirectly receiving payment, other than copayment or deductible, from the health maintenance organization.

The State will screen, enroll, and periodically revalidate all Contractor network providers as Medicaid providers in accordance with 42 CFR 438.602(b)(1). The Contractor may execute provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to one hundred and twenty (120) days but must terminate a network provider immediately upon notification from the State that the provider cannot be enrolled, or the expiration of a one hundred and twenty (120) day period without enrollment of the provider, and notify affected enrollees per 42 CFR 438.602(b)(2).

In some cases, members may receive out-of-network services. A non-participating provider is a provider who does not accept assignment on all Medicaid claims. 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 PathWays 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

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and service coordination, or LTSS provider for three (3) years from the effective date of the PathWays 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 2A, 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 PathWays 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;

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; and

g. The ability to offer HIPAA-secure virtual/tele-health services, as appropriate.

FSSA shall assess liquidated damages as set forth in Exhibit 2A 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 2A 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.

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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 PathWays 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 implement written policies and procedures for selection and retention of network providers as required by 42 CFR 438.12(a)(2) and 42 CFR 438.214(a). 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 PathWays 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 by service and county for both the minimum per county and the required enrollee to provider ratios. See provider table in Section 6.2;
- 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

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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 PathWays. 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, 43 CFR 438.206(b)(1), and 42 CFR 438.206(b)(7), which provides assurances of adequate capacity and services, the Contractor shall:

- Serve the expected enrollment;

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

- Maintain a sufficient number, mix and geographic distribution of providers to meet the needs of the anticipated number of enrollees in the service area per 42 CFR 438.207(b)(2) and as specified below;

- Maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities; and

- Demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services.

In compliance with 42 CFR 438.3(q)(1), 42 CFR 438.3(q)(3) and 42 CFR 438.3(r), the Contractor shall:

- Provide reasonable and adequate information, referral, and treatment for emergency medical conditions; and

- Make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under the Contract can be furnished promptly and without compromising the quality of care.

In accordance with 42 CFR 438.207(b)-(c), 42 CFR 438.604(a)(5), 42 CFR 438.606 and 42 CFR 438.206, in order for the State to certify that the Contractor meets the requirements for availability and accessibility of services, including the adequacy of the provider network, the Contractor shall submit initial and 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 a frequency that complies with the PathWays Reporting Manual and at any time there is a significant change to the Contractor's operations and/or 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 PathWays Reporting Manuals. FSSA shall have the right to expand or revise the network requirements, as it deems appropriate.

The Contractor shall comply with the following in accordance with 42 CFR 438.12(a), 42 CFR 438.12(b), and 42 CFR 438.214(e):

- 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 must comply with any additional provider selection requirements established by the State;

- The Contractor is not precluded from using different reimbursement amounts for different specialties or practitioners within the same specialty; and

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- The Contractor is not precluded from establishing any measure designed to maintain quality and control costs consistent with the Contractor's responsibilities.

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 the PathWays 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(c)(1), 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 ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities per 42 CFR 438.206(c)(3).

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.

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

- 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 physician extenders 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

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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)

A Primary Medical Provider (PMP), also known as a Primary Care Provider (PCP) or primary care doctor, is a primary care physician or other licensed health practitioner practicing in accordance with State law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. At a minimum, providers allowed to serve as PMPs must include physicians, physician assistants, and advanced practice registered nurses.

In general, primary care refers to all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them (see also: 42 CFR 438.2).

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-PathWays 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. The PMP must be afforded the opportunity 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-PathWays 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

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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.

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. A specialist is a doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

As with PMPs, specialist and ancillary providers shall not be limited to serving 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**	▪ Diagnostic testing* ▪ Durable Medical Equipment (see below) ▪ Prosthetic suppliers**

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▪ Hematologists ▪ Infectious disease specialists** ▪ Interventional radiologists** ▪ Nephrologists* ▪ Neurologists* ▪ Neurosurgeons** ▪ Non-hospital-based anesthesiologist (e.g., pain medicine)** ▪ Gynecologists* ▪ Occupational therapists* ▪ Oncologists* ▪ Ophthalmologists* ▪ Optometrists* ▪ Orthodontists* ▪ Orthopedic surgeons* ▪ Otolaryngologists ▪ Pathologists** ▪ Physical therapists* ▪ Psychiatrists* ▪ Pulmonologists* ▪ Radiation oncologists** ▪ Rheumatologists** ▪ Speech therapists* ▪ Urologists*	

FSSA requires that the Contractor maintain network access standards for the listed ancillary providers as follows:

- At least two (2) durable medical equipment providers serving each county shall be available to provide services to the Contractor's members.

Durable medical equipment includes purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicaid (see also: 42 CFR 414.202). See Section 3.13 for additional information on DME.

In addition, the Contractor shall demonstrate the availability of providers with training, expertise, and experience in providing tobacco dependence treatment services. Evidence that providers are trained to provide tobacco dependence treatment services must be available during FSSA's routine 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 serving each county within thirty (30) miles or thirty (30) minutes from a member's residence, as well as at least two (2) durable medical equipment providers serving each county.

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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), credentialed in psychiatric or mental health nursing (applicable education and board certification;
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 providers and qualified behavioral health professionals working under a licensed behavioral health provider as defined in 405 IAC 5-20-8-2.

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:

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- 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 per Section 1903(m)(2)(A)(ix) of the Social Security Act. In accordance with section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA) and 42 CFR 438.14(c)(1), 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

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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 PathWays 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 in- and out-of-network per 42 CFR 438.14(b)(2), and if that Indian healthcare provider participates in the network as a

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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 services in accordance with 42 CFR 438.14(b)(3);

- 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 per 42 CFR 438.14(b)(1) and 42 CFR 438.14(b)(5). 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 438.14(b)(5), 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.

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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, in accordance with the requirements set out in section 1932(h) of the Social Security Act, 42 U.S.C. 1396u-2(h), 42 CFR 438.14(b)(2)(i)-(ii), and 42 CFR 438.14(c)(1)-(2). Non-FQHC Indian healthcare providers, whether in or out-of-network, have a right to receive the Encounter Rate established by the IHS on an annual basis and published in the Federal Register per 42 CFR 438.14(c)(2).

ii. Make prompt payment to all Indian healthcare providers as set forth in Section 9.7.3 and required by 42 CFR 438.14(b)(2)(iii), ARRA 5006(d), 42 CFR 447.45 and 42 CFR 447.46.

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.

iv. Permit all out-of-network Indian healthcare providers to refer eligible members to in network providers per 42 CFR 438.14(b)(6).

In accordance with 42 CFR 438.14(c)(3) and 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,

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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 any willing and able IHCP-enrolled urgent care clinics. The Contractor may utilize the taxonomy code 261QU0200X to help identify urgent care clinics but is not limited by this taxonomy code.

Per 42 CFR 405.400, urgent care services means services furnished to an individual who requires services to be furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition.

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(a)(4) 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 extender types, Advanced Practice Nurses (APNs) and Physician Assistants, may perform services per BT201584 and BT201743.

Additionally, State Medicaid programs are required to make nurse practitioner services available to Medicaid recipients in accordance with 42 CFR 441.22.

According to Indiana law, the following physician extenders are licensed to provide care in Indiana:

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- Advanced practice nurses, including nurse practitioners, nurse midwives and clinical nurse specialists;
- Physician assistants; and
- Certified registered nurse anesthetists.

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 secure conferencing (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

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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 Pay for Outcomes Program stipulated in Exhibit 2A.

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.

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- 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 FSSA 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 Subpart B. 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 PathWays 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.

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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 action 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. The MCE network participation request effective date policy does not apply to providers that utilize delegated credentialing relationships with the MCEs. Under these relationships, providers and MCEs can continue to determine an appropriate effective date. See BT2021109. Providers must be fully enrolled and effective as an IHCP provider prior to becoming effective with the Contractor. The PathWays 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 FSSA, per 455 IAC 2, Home and Community Based Services, before they can serve PathWays enrollees. Once approved and certified, 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 2A. The notice shall be issued in

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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

As required by 42 CFR 438.10(f)(1), 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 on a regular basis going back twelve (12) 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. The requirement to provide notice thirty (30) calendar days prior to the effective date of disenrollment/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 CFR 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.

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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-PMP provider when possible. However, if the non-PMP provider 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.

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 or LPI 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

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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's network of providers must be credentialed as required under 42 CFR 438.214(b) and 42 CFR 438.206(b)(6). In all contracts with network providers, the Contractor must follow a documented process and the State's uniform credentialing and recredentialing policy, as appropriate per 42 CFR 438.12(a)(2) and 42 CFR 438.214(b). 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 Contractor 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) and 42 CFR 438.12(a), 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.

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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 Contractor's credentialing and recredentialing process, policies and procedures are subject to review by OMPP at any time. Non-licensed HCBS providers are subject to recertification on a cycle as set forth by IHCP. Failure to complete the recertification process or respond to any IHCP requests for verification may lead to provider decertification. Refer to the MCE Policies and Procedures manual for additional information on the decertification process.

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). 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.

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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

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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 than 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 claim 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.

The Contractor's in-network provider claim dispute process must adhere to the same rules laid out for out-of-network providers in 405 IAC 1-1.6-1

In accordance with 42 CFR 438.60, no payments should be made to a network provider other than by the Contractor for services covered under the Contract with the State, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act.

6.10 Medical Records

The Contractor shall ensure that providers maintain and share member health records in accordance with professional standards per 42 CFR 438.208(b)(5). 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;

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- 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. 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 2A. FSSA encourages Contractors to use technology, including participation in health information exchanges, where appropriate to transmit and

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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 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.

The Contractor is responsible for conducting settings rule site visits to ensure adherence to 42 CFR 441.301(c). A member's service plan must account for member preferences and provider compliance as described in Section 4.10 Service Plan. Refer to the MCE Policies and Procedures manual for additional settings rule guidance.

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.

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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;

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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 42 CFR 438.102;

11. Provider responsibility and the Contractor's expectation of the Provider;

12. Provider non-discrimination information;

13. Expected response times for provider inquiries (telephone contacts, letters, emails, faxes);

14. 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;

15. Other significant Contractor policies affecting providers such as nursing facility and HCBS setting contract termination procedures;

16. TPL and/or coordination of benefits policy;

17. Member cost sharing requirements;

18. Medical record standards;

19. Credentialing and re-credentialing activities;

20. Claims medical review; medical necessity standards and clinical practice guidelines;

21. Coordination and/or transition of care responsibilities;

22. Needs assessment and/ service planning requirements;

23. Information on how members may access specialists;

24. Person-centered thinking and cultural competency information including accessing interpretation services to assist members who speak another language;

25. Specific policy for drug, alcohol and/or behavioral health treatment availability and referral processes;

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26. Formulary and exception process information;

27. Missed appointment and follow-up responsibilities;

28. Fraud, waste, and abuse responsibilities;

29. Frequently asked questions and answers;

30. Appointment standards;

31. Encounter validation studies;

32. Incident, accident, and death reporting;

33. Information regarding Contractor offered education or training, workforce development requirements and information;

34. 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;

35. Procedures for a provider to report to when a provider has received an overpayment, to return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment per 42 CFR 438.608(d)(2); and

36. Policies and procedures for member grievance, appeal, and fair hearings, availability of member assistance and the member's right to request continuation of benefits, in accordance with 42 CFR 438.414 and 42 CFR 438.400-424 and 42 CFR 438.10(g)(2)(xi)(A)-(E).

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,

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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,

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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.

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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.

All member related documents that are necessarily shared with the member's respective provider(s) must reference the member's Indiana Medicaid ID number. No other number, including the Contractor's internal system tracking number, may be included and/or referenced on member documents. This does not apply to members in an aligned D-SNP. Member and provider communications may have the required Medicaid ID number and also include the D-SNP health plan ID number.

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;

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- 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 PathWays 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.

The Contractor shall provide a secure portal for providers to conduct business transactions including, but not limited to electronic claims submission, prior authorization submission, grievance and appeals submission and tracking, etc. This portal must be compliant with all IT requirements identified in Section 9 Information Technology (IT) Systems and approved by the State.

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 PathWays program. 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

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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 PathWays 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)(i), 42 CFR 438.3(g) and 42 CFR 447.26(b), no payment shall be made by the Contractor to a provider for a provider-preventable condition as identified in the State Plan when the following criteria are met:

- Is found by the State or Contractor, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
- Has a negative consequence for the beneficiary.
- Is auditable.
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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 March 30, 2023 (BT202326), as well as any updates or amendments thereto. IHCP follows the CMS determinations for hospital-acquired conditions (HACs) that will not be considered for payment if the diagnoses were not present on admission (POA).

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), 438.3(g) and 42 CFR 434.6(a)(12)(ii). 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.

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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), 42 CFR 438.3(g), and 42 CFR 434.6(a)(12)(ii). 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, 42 CFR 438.3(k), 42 CFR 438.230 and Section 1932(b)(1)-(2) and (6) of the Social Security Act, the Contractor and its subcontractors shall ensure that its providers do not balance bill its members and 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 contract provides that if the MCE imposes premiums or charges on enrollees that are in excess of those permitted in the Medicaid program, in accordance with 42 CFR 438.700(b)(2), the state may impose a civil monetary of up to $25,000 or double the amount of the excess charges (whichever is greater) and may enforce other corrective actions as described in Exhibit 2A. If the State imposes a civil monetary penalty on the Contractor for this violation, the State will deduct the amount of the overcharge from the penalty and return it to the affected enrollee per 42 CFR 438.704(c).

Per 42 CFR 447.51, premium means any enrollment fee, premium, or other similar charge.

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 per 42 CFR 438.3(k), 42 CFR 438.230(c)(1)-(2), and section 1932(b)(6) of the Social Security Act. 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;

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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; and
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.

PathWays 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. Per IC 27-13-1-8, copayment means an amount, or a percentage of the charge, that an enrollee must pay to receive a specific service that is not fully prepaid.

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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. As required by 42 CFR 438.10(h)(3)(ii), provider network information on the Contractor's website must be updated no later than thirty (30) calendar days after the Contractor receives updated provider information. Network provider information shall be available to print from a remote user location and in a machine-readable file and format as specified by the Secretary per 42 CFR 457.1207 and 42 CFR 438.10(h)(4). 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 (42 CFR 438.10(h)(3)). 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 all PMPs, 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;

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- Whether the provider has completed cultural competence training; and

- Accessibility and accommodations of the provider's premises for people with physical disabilities, 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:

PathWays 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 PathWays program 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 2A. The State may change these objectives and measures annually, with at least sixty (60) days' notice to Contractor.

7.1 Quality Management and Improvement Program

In accordance with 42 CFR 438.330, NCQA, and CMS standards, as well as the State-defined elements, Contractor shall develop and implement an ongoing Quality Assessment and Improvement Program (QMIP) for all services it provides to its members.

The Contractor's Medical Director shall be responsible for the coordination and implementation of the Quality Management and Improvement Program. The program shall be based on professional standards; the purpose of the program is to assess and monitor the health care services provided to the members enrolled in the organization per IC 27-13-6-1(a); establish procedures that assess the availability, accessibility, and continuity of care of services as well as implement any corrective actions if necessary, per IC 27-13-6-1(b). The State will identify certain performance measurements that will be outlined in the Quality Strategy Plan including those specified by CMS [42 CFR 438.330(c)(1)(i)].

The Contractor is expected to measure and report data to the State on its performance measures based on the frequency set forth in the Managed Care Entity (MCE) Reporting Manual or as requested by the State [42 CFR 438.330(c)(2)] as a means to monitor and evaluate quality performance of the program. Specifically, the Contractor is required to provide HEDIS and CAHPS data per MCE Reporting Manual.

The program shall have objectives that are measurable, realistic and supported by consensus among the Contractor's medical and quality improvement staff.

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

The State requires that the Quality Management and Improvement Program at a minimum must include according to IC 27-13-6-3:

(1) A written statement of the scope and purpose of the quality management program, including a written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to its members. This may be included as part of the Quality Management and Improvement Program Description. The statement must describe quality improvement activities including the following IC 27-13-6-4:

- Problem assessment, identification, selection, and study.
- Corrective action, monitoring, evaluation, and reassessment.
- Interpretation and analysis of patterns of care rendered to individual patients by individual providers.
- Comparison between patterns of care, including outcomes, rendered to patients by providers and the cost to the health maintenance organization of that care.
- A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation, and report format.

(2) The organizational structure responsible for quality management activities.

(3) Any contractual arrangements, when appropriate, for delegation of quality management activities.

(4) Confidentiality of policies and procedures.

(5) A system of ongoing evaluation activities.

(6) A system of focused evaluation activities.

(7) A system for credentialing providers and performing peer review activities.

(8) Duties and responsibilities of the designated physician responsible for the quality management activities.

In addition, the State requires the Contractor's QMIP program to have mechanisms in place that evaluate the health care services provided by primary care and specialist physicians and those provided by ancillary and preventive health care services across all care settings (IC 27-13-6-2).

It is also the responsibility of the Contractor to have procedures in place to monitor and act on quality opportunities including corrective action, if appropriate, for health care services provided that do not meet standards of care. There must be written plans in place that address appropriate action to take when it is determined that inappropriate or substandard services have been provided or when there were services that should have been provided were not provided (IC 27-13-6-5).

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

According to IC 27-13-6-6, the Contractor shall utilize and maintain member record systems to facilitate documentation and retrieval of clinical information for the purpose of evaluating care coordination as well as assess the quality of health and medical care being provided.

The Contractor shall also include Performance Improvement Projects (PIPs), including any required by the State or CMS, that focus on clinical and non-clinical areas in compliance with 42 CFR 438.330(b)(1), 42 CFR 438.330(d)(1)-(3), and 42 CFR 438.330(a)(2). Each PIP shall include:

- A design to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction;
- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- An evaluation of the effectiveness of the interventions based on the performance measures collected as part of the PIP; and
- Planning and initiation of activities for increasing or sustaining improvement.

The Contractor shall report the status and results of each PIP to the State as required in the MCE Reporting Manual.

The Contractor shall meet the requirements of 42 CFR 438 subpart E on Quality Assessment and Performance Improvement and the National Committee for Quality Assurance (NCQA), including but not limited to the requirements listed below, in developing its Quality Assessment and Performance Improvement Program and the Quality Assessment and Performance Improvement Program Work Plan. In doing so, it shall include (i) an assessment of quality and appropriateness of care provided to members with special needs, (ii) complete performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects; and (iii) produce quality of care reports at least annually.

The Contractor's Quality Assessment and Performance Improvement Program shall comply with 42 CFR 438.330(b)(2)-(4), 42 CFR 438.330(c), 42 CFR 438.330(a)(2), 42 CFR 438.340 and include the following:

- Include developing and maintaining an annual Quality Management and Improvement Program Work Plan which sets goals, establishes specific objectives, identifies the strategies and activities to undertake, monitors results and assesses progress toward the goals.
- Have in effect mechanisms to detect both underutilization and overutilization of services. The activities the Contractor takes to address underutilization and overutilization must be documented.
- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.
- Incorporate an internal system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment

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of quality and appropriateness of care furnished to special needs populations and other quality improvement activities requested by FSSA.

- Participate appropriately in clinical studies and use Healthcare Effectiveness Data and Information Set ® (HEDIS®) rate data and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.

Collect measurement indicator data related to areas of clinical priority and quality of care. FSSA will establish areas of clinical priority and indicators of care. FSSA reserves the right to identify additional conditions at any time, as the areas reflect the needs of the Indiana Medicaid populations. These areas may vary from one year to the next and from program to program.

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.

Contractors providing long term support services must have mechanisms and processes in place to determine appropriateness of care and the handling of critical incidents as part of their QMIP (42 CFR 438.330 (b)(5)(I)(ii)). These mechanisms and processes must include:

- Assessment of quality and appropriateness of care between care settings
- Comparing services and supports received to ensure alignment with care/service planning
- Detect, prevent, monitor, track and trend, and investigate critical incidents in compliance with State critical incident policy for home based and community services (HCBS)

The Contractor's QMIP shall address and support the PathWays Program goals and objectives as outlined in the State Quality Strategy Plan. To that end, the Contractor must perform the activities listed below and must address each of these elements in its annual QMIP description 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. Include at least one initiative, consistent with the requirements in Section 6.1, each year to address equity;
3. 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;
4. 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

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5. Produce quality of care reports in the format and at the frequencies specified in Section 10 and the MCE Reporting Manual.

The PathWays 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 with LTSS distinction 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 PathWays 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 documents 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 438.330(b), NCQA Quality Improvements Standards, 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.

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- 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 for individuals with special health care needs, including both physical and behavioral health as well as long-term services and supports for all members, with a special focus on the following:
        - 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

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delivered to members in the PathWays 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 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

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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 PathWays 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.

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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 the Contractor's PathWays 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 PathWays 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 PathWays, shall not cover other states or lines of business and shall include prospective activities over a three (3) year period. The plan shall meet NCQA HEDIS standards for reporting and measuring outcomes, and shall:

- Describe specific activities to support PathWays Quality Goals

- Include participation, as directed by FSSA, in collaborative efforts with FSSA and other PathWays 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.

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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 a PathWays 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 the

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Contractor's PathWays 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, the Contractor's PathWays 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 PathWays 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 May 31st of the Contract Year.

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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 May 31st 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 for responding 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 PathWays 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

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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 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; and

- 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;

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4. Monitor access to providers and verify that authorized services were actually provided;

5. Detect, identify and remediate Unusual Occurrences consistent with PathWays requirements per Section 7.1.14;

6. Monitor the quality of any subcontractors; and

7. Appeals and grievances were resolved as requested by the members.

7.1.9 External Quality Review

Pursuant to federal regulation 42 CFR 438.358 (b)(c), the State shall arrange for an annual, external independent review of each Contractor's quality of, timeliness of and access to health care services in accordance with 42 CFR 438.350. 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

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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 2A 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 the PathWays 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 the Contractor's PathWays 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 PathWays program. 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;

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5. Free Choice of Provider in accordance with 42 CFR 431.51 as amended by the 1915(b) waiver for PathWays;

6. FFP Limitation in accordance with 42 CFR 441.310;

7. Fair Hearing in accordance with 42 CFR 431 Subpart E;

8. Quality Improvement including all performance measures related to these assurances; and

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

The Contractor is responsible for reporting all critical incidents related to its members, according to the two categories listed below. First, HCBS Critical Incidents are defined as incidents occurring in a HCBS setting that fall in the category of unusual occurrences. These include incident types listed in 455 IAC 2-8-2 Protecting Individuals (Unusual Occurrence; Reporting) as well as additional incident types as described below. Second, please note that a subset of the incident types in 455 IAC 2-8-2 are defined separately for purposes of this scope of work (see below, "ANE Critical Incidents") due to differing Contractor obligations.

HCBS Critical Incidents include but are not limited to, the following, as applicable:

1. Injuries of unknown origin

2. Significant injuries to the member including, but not limited to, the following:

    (A) A fracture.
    (B) A burn greater than first degree.
    (C) Choking that requires intervention.
    (D) Contusions or lacerations.

3. Suicidal ideation or suicide attempt that had the potential to cause physical harm, injury, or death

4. Admission of an individual to a nursing facility, excluding respite stays

5. Member elopement or missing person

6. Inadequate formal or informal support for a member, including inadequate supervision which endangers the member

7. Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs

8. A residence that compromises the health and safety of a member due to any of the following:

    (A) A significant interruption of a major utility
    (B) An environmental, structural, or other significant problem

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9. Environmental or structural problems associated with a dwelling where individuals reside that compromise the health and safety of the individuals

10. A residential fire resulting in any of the following:

    (A) Relocation.
    (B) Personal injury
    (C) Property loss

11. Suspected or observed criminal activity by:

    (A) A staff member, employee, or agent of the provider
    (B) A family member of a member receiving services
    (C) The individual receiving services; when the care of the individual is impacted or potentially impacted

12. Police arrest of a member or any person responsible for the care of the member

13. A major disturbance or threat to public safety created by the member. The threat:

    (A) can be:
        (i) toward anyone, including staff; and
        (ii) in an internal setting; and
    (B) need not be outside the individual's residence

14. Any use of restraint that results in harm to the member

15. Falls with injury, in accordance with the U.S. Center for Disease Control's (CDC) Behavioral Risk Factor Surveillance System (BRFSS)

For the purposes of this contract, the following types of critical incidents identified in 455 IAC 2 are not considered HCBS Critical Incidents. However, these incidents do meet the definition of abuse, neglect, and exploitation (ANE) and are categorized, for the purposes of this Scope of Work, as "ANE Critical Incidents." They include:

1. Alleged, suspected, reported, observed, or actual abuse, neglect, or exploitation of a member.

2. Death of a member.

All providers of HCBS services, including Service Coordinators, are required to submit incident reports to FSSA when any of the events in Section 7.1.14 are identified, including both HCBS Critical Incidents and ANE Critical Incidents.

Incident reports shall be submitted through the FSSA web-based Incident Reporting and Incident Follow Up Reporting (IFUR) System or the successor system, as designated by FSSA. If web access is unavailable, incidents can be reported to FSSA by telephone or 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

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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 all critical incidents and shall review and analyze the critical incidents to identify and address as potential and actual quality of care and/or health and safety issues. For all types of critical incidents, the Contractor shall assess and address any immediate potential threats to member health, safety, and welfare. For ANE Critical Incidents the Contractor shall also cooperate with state agencies' investigations of and resulting actions related to ANE and all other types of critical incidents. 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 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 PathWays HCBS. The Contractors shall follow all process steps and 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, Home and community Based Services (HCBS) and Nursing Home
    ii. National Core Indicators Survey: Aging and Disabilities (NCI-AD)
- Informal Caregiver Survey
- Provider Surveys
    i. National Core Indicators Aging and Disabilities (NCI-AD): State of the Workforce (SOTW) Survey
    ii. Provider Satisfaction survey
- Additional 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 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.

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The Contractor shall provide survey results to the State (including de-identified member-level data when available) 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 QAPI program. 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, sampling plan 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 2A.

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 (when required) to perform annual CAHPS surveys in accordance with AHRQ and or NCQA standards. The Contractor shall use the most current CAHPS version specified by AHRQ or NCQA at the time of survey administration. The survey must be conducted in accordance with AHRQ and NCQA guidelines, if available (i.e.: Health Plan CAHPS).

The 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, if required) by July 31st of each calendar year beginning in 2026 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 State reserves the right to approve any Contractor-specific supplemental questions. The State may require the Contractor to include supplemental questions. The State may require the addition of up to six (6) supplemental state-specific questions at no additional cost to the State.

For all CAHPs surveys, the Contractor will, at least one hundred and eighty (180) days prior to the administration of the survey, provide the State with the sample size and sampling methodology. The sampling methodology will be designed to oversample to allow for statistically representative measurement of equity by age, race/ethnicity, language and other factors as available.

The Contractor shall have its Health Plan CAHPS sample validated by an NCQA-certified HEDIS Auditor. For all surveys, the sample size will be determined based on CMS technical assistance, or AHRG guidance. To increase response rates in order to meet the target number of completed surveys, the Contractor may oversample, send a

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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 State reserves the right to define additional stratification requirements. Each CAHPS survey must be based upon the AHRQ methodology for sampling of CAHPS data, NCQA for Health Plan CAHPS. Required CAHPS surveys will include:

- CAHPS Health Plan Survey
- CAHPS Nursing Home Surveys (all three standardized surveys):
    - Long-stay Resident Survey
    - Discharged Resident Survey
    - Family Member Survey

The State will administer the CAHPS Home and Community Based Services Survey and share the results with the Contractor. The Contractor is expected to develop action plans to address areas of concern and opportunity. The contractor is also expected to report the results of these activities back to the state as part of their annual QAPI evaluation.

The MCE's independently-administered CAHPS surveys listed above shall be conducted solely for Contractor's PathWays line of business.

During the first two years of the program, the State will conduct quarterly member experience surveys as designed by the State and based on a subset of the HCBS CAHPS survey tool questions, in order to facilitate regular rapid cycle feedback and quality improvement for the PathWays program. The Contractor is responsible to meet a minimum number of completed surveys based on State requirement. To increase response rates in order to meet the target number of completed surveys, the Contractor shall send a pre-notification letter and/or postcard to potential survey participants to let them know they may be called to participate in the survey.

7.2.2 National Core Indicators Survey- Aging and Disabilities (NCI-AD)

The State will conduct an annual quality of life survey for members enrolled in PathWays using the National Core Indicators – Aging and Disabilities consumer survey. To support this effort, Contractor may be asked to 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 will be required to review survey results and develop corrective action plans or quality improvement projects.

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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 PathWays 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 the Contractor of the survey timing and approach at least ninety (90) days prior to survey administration. The administration of a caregiver survey specific to enrollees in PathWays may be considered for future years.

7.2.4 Provider Surveys

7.2.4.1 National Core Indicators- Aging and Disabilities (NCI-AD) State of the Workforce (SOTW) Survey

The State may conduct an annual National Core Indicators – Aging and Disabilities State of the Workforce (NCI-AD SOTW) survey for providers enrolled in PathWays. To support this survey the plans may be asked to provide a list of providers who employ Direct Service Workers as well as contact information (name, email, telephone number) for the person at the provider office who would receive and complete the survey. The plans may be asked to provide additional assistance as needed by the State. The Contractor will be required to review survey results and develop quality improvement projects, as needed.

7.2.4.2 Provider Satisfaction surveys

The Contractor may be required to administer provider satisfaction surveys. Survey questions and survey methodology must be submitted to the State for review and approval; the State may require standard questions to be included.

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.

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 PathWays 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-

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performing providers. Informed by national best practices, FSSA will design its VBP program to support progress in achieving the PathWays 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 PathWays 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 PathWays 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 PathWays 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 PathWays 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 PathWays 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 PathWays members. The P4O program will at a minimum incentivize objectives that support the

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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 2A.

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 PathWays Quality Goals or to distribute a portion of the P4O payment to its network providers in support of the PathWays 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 2A.

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 PathWays 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.

- Understanding and assessing social determinants of health (SDOH) and connecting with social services providers to address member and informal caregiver SDOH needs.

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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 PathWays 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 PathWays 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 the Contractor's PathWays 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 PathWays 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 438.3(i), 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

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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 per Section 1903(m)(2)(A)(x) of the Social Security Act, 42 CFR 422.208(c)(1), and 42 CFR 438.3(i); and

- The Contractor shall meet requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.3(i), 42 CFR 422.208(c)(2) and Section 1903(m)(2)(A)(x) of the Social Security Act.

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 three hundred dollars ($300.00) per member per year (aggregate total), 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 three hundred dollars ($300.00) per year per individual if the items are intended to promote the delivery of certain preventive care services, as defined in 42 CFR 1003.110. 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 1003.110:

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"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 PathWays 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 may place appropriate limits on coverage on the basis of medical necessity or utilization control criteria, provided the Contractor ensures that the amount, duration and scope of services furnished can reasonably be expected to achieve their purpose and the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services per 42 CFR 438.210(a)(3)(i), 42 CFR 438.210(a)(4)(ii)(A)-(B). 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 is prohibited from arbitrarily denying or reducing the amount, duration or scope of required services solely because of diagnosis, type of illness or condition as required by 42 CFR 438.210(a)(3)(ii). The Contractor will not refer members to publicly supported health care resources as a means of avoiding costs.

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

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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

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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 in accordance with 42 CFR 438.210(b)(3) and 42 CFR 438.210(c). 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 or doctorate-level behavioral health clinicians 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 per 42 CFR 438.210(e). 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 criterion 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.

The following utilization management medical criteria hierarchy have been effective for all managed care programs beginning April 1, 2023.

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

For select items, MCEs must use IHCP Policy as outlined below. For all other items where OMPP has criteria or guidelines in place, the MCE cannot have criteria or guidelines that are more restrictive. The MCE must use the full suite of non-company customized InterQual or Milliman Care Guidelines (MCG) clinical guidelines, inclusive of Medicare National Coverage Determinations and Medicare Local Coverage Determinations. For areas not addressed by IHCP Policy and MCG/InterQual, the MCE may develop their own prior authorization--medical necessity guidelines and criteria, but they must be approved by the state and made available to the state. The hierarchy for clinical criteria and guidelines is outlined below.

Medical review criteria must follow the following hierarchy:

1. Federal law – All review criteria must comply with federal law (if the Code of Federal Regulations has any Medicaid-specific requirements—Indiana Medicaid must comply)

2. Indiana Code—All review criteria must comply with Medicaid-specific provisions of the Indiana Code

3. State Plan—Review criteria are subject to the terms of the state plan (which is our agreement with CMS outlining the coverage and reimbursement of Indiana Medicaid services)

4. Indiana Administrative Code—All review criteria must comply with Medicaid-specific provisions of the Indiana Administrative Code (which is given authority from the Indiana Code)

5. IHCP Policy—This includes Provider Reference Modules, Bulletins, Banners.

    - MCEs must follow IHCP Policy (FFS criteria) exactly for these below items:

        ABA Therapy: Bulletins
        http://provider.indianamedicaid.com/ihcp/Bulletins/BT201867.pdf,
        http://provider.indianamedicaid.com/ihcp/Bulletins/BT201953.pdf,
        Module - https://www.in.gov/medicaid/providers/files/behavioral-health-services.pdf

        Drug Testing: Bulletins
        http://provider.indianamedicaid.com/ihcp/Bulletins/BT201846.pdf,
        http://provider.indianamedicaid.com/ihcp/Bulletins/BT202183.pdf,
        Module - https://www.in.gov/medicaid/providers/files/laboratory-services.pdf

        EndoPredict-Breast Cancer: Bulletin
        http://provider.indianamedicaid.com/ihcp/Bulletins/BT202010.pdf

        Hysterectomies: Bulletin
        http://provider.indianamedicaid.com/ihcp/Bulletins/BT201976.pdf,
        Module - https://www.in.gov/medicaid/providers/files/obstetrical-and-gynecological-services.pdf

        ReliZorb: Bulletin
        http://provider.indianamedicaid.com/ihcp/Banners/BR202050.pdf

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Speech Generating Devices: Bulletin
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202012.pdf

Spinal Stenosis: Bulletin
http://provider.indianamedicaid.com/ihcp/Bulletins/BT2020111.pdf

Transplants: Bulletin
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202019.pdf,
Module -
https://www.in.gov/medicaid/providers/files/surgical-services.pdf

Bariatric Procedures: Bulletin
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202240.pdf,
Module -
https://www.in.gov/medicaid/providers/files/surgical-services.pdf

Oxygen Usage: Bulletin
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202242.pdf,
Module -
https://www.in.gov/medicaid/providers/files/durable-and-home-medical-equipment-and-supplies.pdf

6. Non-Customized National Clinical Guidelines – The MCE may choose to use either InterQual or MCG but must use the full suite of review criteria in these platforms—INCLUDING the Medicare National Coverage Determinations (NCDs) and the Medicare Local Coverage Determinations (LCDs).

    - If an item is covered by MCG or InterQual—the MCE must use the applicable MCG or InterQual guideline in lieu of an MCE-derived guideline.

    - The MCG and InterQual guideline hierarchy is as follows:

        - Must use diagnosis or procedure-specific guidelines before more general guidelines

        - Medicare (MCR) guidelines are to be used in this order: NCDs, then LCDs for Indiana

7. MCE-derived Guidelines (must be pre-approved by the state)

8. Professional Society Guidelines—Guided by published peer-reviewed literature (can supersede National and MCE-derived guidelines if specifically called out to be used in the Scope of Work—i.e., ASAM)

9. Professional References/SME—Guided by published peer-reviewed literature

10. Best Standards of Care—Guided by published peer-reviewed literature

OMPP reserves the right to add additional or remove the Fee-for-Service Criteria and will provide the MCEs with appropriate notice.

The Contractor is expected to always use MCG or InterQual for the following utilization management reviews: acute inpatient, skilled nursing facility, acute inpatient

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rehabilitation, long-term acute care facility and behavioral health inpatient. Skilled nursing care is a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse) (see also: 42 CFR 409.44(b)).

For areas not addressed by IHCP defined hierarchy, the Contractor may develop their own practice guidelines and criteria, but it must be approved by the State and made available to the State. In accordance with 42 CFR 438.236(b)(1)-(2), 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)(3), 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 per 42 CFR 438.210(b)(1) and 42 CFR 438.210(b)(2)(i)-(ii). The Contractor shall ensure that decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply are consistent with such practice guidelines per 42 CFR 438.236(d). 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 long-term level of care is determined. For example, if a member is determined eligible for long-term nursing facility nursing facility level of care including the necessary PASRR 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.

Short-term nursing facility care is temporary medical aftercare following a surgery, injury, illness, or other medical condition that is expected to improve. Services are goal-oriented and typically last several weeks or a few months depending on the severity of the condition being treated. The Contractor is responsible for obtaining services for its members in a skilled nursing facility setting on a short-term basis. The Contractor is responsible for completing a clinical review for each admission. The Contractor is responsible to start member discharge planning on the day of admission to the nursing facility. The Contractor will complete concurrent reviews of a member's short-term nursing facility care to assess medical necessity for continued stay.

Long-term nursing facility care is ideal for members with chronic or progressive medical conditions, such as Parkinson's disease, permanent disabilities, dementia, or

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a debilitating stroke. This is a permanent placement for members who will permanently reside in the nursing facility and is not expected to return home. The Contractor must have processes in place to monitor all long-term nursing facility stays. Contractor must assign a service coordinator to all its members residing in a long-term care facility.

It is the responsibility of the Contractor not to impose burdensome review criteria on nursing facility providers. This includes frequent requests for clinical documentation. Frequent requests are requests requiring providers to submit clinical documentation at a frequency of less than every seven (7) days. The state reserves the right to review the Contractor's policies and procedures regarding medical necessity at any time.

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.

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Effective July 1, 2023, MCEs are expected to meet Prior Authorization timeliness standards per IC 27-1-37.5-11. The change includes standard Prior Authorization adjudication in five business days and urgent Prior Authorization adjudication within 48 hours. Unless otherwise provided in IC 27-1-37.5-8 and IC 27-1-37.5-11

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 as required by CFR 438.210(c). 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 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 five (5) business days or seven (7) calendar days (whichever comes first) 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. If the Contractor fails to respond to a member's prior authorization request not pertaining to medications within five (5) business days or seven (7) calendar days (whichever comes first) of receiving all necessary documentation, the authorization is deemed to be granted.

c. 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. This expedited authorization decision process also applies to requests related to HCBS. 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 per 42 CFR 438.210(d)(2)(ii). The Contractor will be required to provide its justification to FSSA upon request.

d. For expedited authorization requests related to HCBS, the decision to deny authorization for services contained in the member's Service Plan requires that the Contractor provide notice to the member within 24 hours. Under no conditions may the Contractor extend this timeframe.

e. 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.

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f. For concurrent reviews within forty-eight (48) hours.

g. 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. In accordance with 42 CFR 438.404(c)(1), 42 CFR 431.213, 42 CFR 431.231(d), and section 1919(e)(7) of the Social Security Act, 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 are 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.

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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 are available and how to request it;
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services; and
- The provider's right for a peer-to-peer utilization review conversation with the reviewer including the process for scheduling a peer-to-peer utilization review conversation and that the provider has fifteen (15) business days to 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 State reserves the right in the future to prohibit the Contractor from requiring prior authorization when it is not required in fee-for-service.

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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 requester; (b) title of requester; (c) date and time of request; (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); (f) denial notification letter for both members and providers; (g) date and time of denial notification as well as the name of the individual notified of denial; and (h) evidence that the treating practitioner was notified of appeal rights including a peer to peer review when appropriate.

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 referrals. 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)(4), 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

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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 in compliance with 42 CFR 438.102(b)(1)(i)(B) and 42 CFR 438.10(g)(4).

The Contractor shall provide members and potential enrollees with information on how and where to obtain counseling and referral services and if the Contractor chooses not to furnish the information, the State will provide the information to potential enrollees in accordance with 42 CFR 438.10(e)(2)(v)(C)

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:

- Providing oversight of the Contractor UM program and structure
- Involvement of physician and behavioral health providers in the review, evaluation, and supervision of UM activities
- 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,

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- 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.

In accordance with 42 CFR 438.3(h), the State, CMS, the OIG, the Comptroller General, and their designees have the right to:

- Inspect and audit records or documents of the Contractor and their subcontractors at any time.
- Inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time.
- Audit records or documents of the Contractor or 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.
- Audit and inspect any books or records of the Contractor or subcontractor pertaining to the ability of the Contractor to bear the risk of financial losses and pertaining to services performed or payable amounts under the contract per section 1903(m)(2)(A)(iv) of the Social Security Act.

Contractors shall ensure that subcontracts specify the above and other specified information regarding the State and other Federal agency rights as required in 42 CFR 438.230(c)(3)(i) and 42 CFR 438.3(k).

In accordance with 42 CFR 438.608(c)(2), 42 CFR 455.100-104, section 1124(a)(2)(A) and section 1903(m)(2)(A)(viii) of the Social Security Act, the Contractor and subcontractors shall disclose to the State any persons or corporations with an ownership or control interest in the Contractor that:

- Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity;
- Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets;
- Is an officer or director of the Contractor organized as a corporation; or
- Is a partner in the Contractor organized as a partnership.

Disclosure of the ownership or control interest information described above shall be made to the State at the following times:

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- Upon proposal submission in accordance with the State's procurement process;
- When the Contractor executes a contract with the State;
- When the State renews or extends the Contract; and/or,
- Within thirty-five (35) days after any change in ownership of the Contractor.

The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR 455.100-107) on disclosure reporting, including business transaction disclosure reporting (42 CFR 455.105) and shall further provide any additional information necessary for FSSA 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 455.104-107 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.

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

- Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XIX, XX, or XXI under Sections 1128, 1128A, 1156, or 1842(j)(2) and 1903(i) and 1903(i)(2)(A) of the Social Security Act.
- Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to Section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person) per Section 1903(i) and 1903(i)(2)(B) of the Social Security Act.
- Furnished by an individual or entity to whom the State has failed to suspend payments during any period in which the State has notified the Contractor of a pending investigation

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of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments per Section 1903(i) and 1903(i)(2)(C)) of the Social Security Act.

- With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 per Section 1903(i)(16) of the Social Security Act.

- With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan per Section 1903(i)(17) of the Social Security Act.

Federal Financial Participation (FFP) is not available for any amounts paid to a Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

- The Contractor is controlled by a sanctioned individual under Section 1128(b)(8) of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(1), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3); SMDL 6/12/08, SMDL 1/16/09],

- The Contractor has a contractual relationship for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as specified in Section 1128(b)(8)(B) of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08; SMDL 1/16/09],

- The Contractor has a contractual relationship for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual or entity that is, or is affiliated with a person or entity that is, debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 per 42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 438.610(b), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09, Executive Order No. 12549],

- The Contractor has a contractual relationship for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with any individual or entity excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 438.610(b), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09],

- The Contractor employs or contracts directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 per 42

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CFR 438.808(a), 42 CFR 438.808(b)(3)(i), 42 CFR 438.610(a), 1903(i)(2), 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, and SMDL 1/16/09,

- The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity, or with an individual or entity that would provide those services through an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act per 42 CFR 438.808(a), 42 CFR 438.808(b)(3)(i)-(ii), 42 CFR 438.610(b), Section 1903(i)(2) of the Act, 42 CFR 1002.3(b)(3), 42 CFR 1001.1901(c), SMDL 6/12/08, and SMDL 1/16/09, and/or

- The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 per 42 CFR 438.808(a), 42 CFR 438.808(b)(3)(ii), 42 CFR 438.610(a), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08 and SMDL 1/16/09.

If the State learns that the Contractor has a relationship with any of the above prohibited individuals or entities, FSSA will notify the Secretary of noncompliance and determine if this Contract will be continued or terminated in accordance with 42 CFR 438.610(d)(2)-(3), 42 CFR 438.610(a)-(b). The State may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

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. In accordance with 42 CFR 438.608(a)(1)(i)-(vii) and 42 CFR 438.230 the Plan shall include in its PI Plan provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of Contractor's providers, vendors, and subcontractors (including but not limited to Pharmacy Benefits Managers) and Contractor itself, including:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.
- The designation of a Special Investigation Unit Manager, a Compliance Officer and a Compliance Committee. The Plan should document that the Compliance Officer and SIU Manager shall meet with the OMPP PI Section at a minimum of quarterly and as directed by the OMPP PI Section.
- The type and frequency of training and education for the Special Investigation Unit Manager, Compliance Officer, and the organization's employees who will be

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provided to detect fraud. Training must be annual and address the False Claims Act, Indiana laws and requirements governing Medicaid reimbursement and the utilization of services – particularly changes in rules, and other federal and state laws governing Medicaid provider participation and payment as directed by CMS and FSSA. Training should also focus on recent changes in rules.

- A risk assessment of the Contractor's various fraud and abuse/program integrity process. 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.
- An organizational chart and communication plan highlighting lines of communication between the Special Investigation Unit Manager, the Compliance Officer, and the organization’s employees.
- Provision for internal monitoring and auditing.
- Procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this contract.
- A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:
    - A list of automated pre-payment claims edits.
    - A list of automated post-payment claims edits.
    - A list of types of desk audits on post-processing review of claims.
    - A list of reports for provider profiling and credentialing used to aid program and payment integrity reviews.
    - A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.
    - A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials.
    - A list of references in provider and member material regarding fraud and abuse referrals.
    - A list of provisions for the confidential reporting of PI Plan violations to the designated person.
    - A list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports.
- Provisions ensuring that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.
- Specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud and abuse compliance PI Plan violations.

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- 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.

- Assurances that no individual who reports Contractor's potential violations or suspected fraud and abuse is retaliated against.

- Policies and procedures for conducting both announced and unannounced site visits and field audits to providers defined as high risk (including but not limited to providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

- Provisions for prompt response to detected offenses, and for development of corrective action initiatives.

- Program integrity-related goals, objectives, and planned activities for the upcoming year.

8.2 Program Integrity Operations

The Contractor shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 42 CFR 456.4, and 42 CFR 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 2A 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.

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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 per 42 CFR 455.23.

- 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.

In accordance with 42 CFR 438.608(a)(3)-(8), the Contractor or subcontractor, to the extent that the subcontractor is delegated responsibility for coverage of services and payment of claims, shall implement and maintain arrangements or procedures for:

- Prompt notification to the State when information is received about changes in a member's circumstances that may affect the enrollee's eligibility including changes in the enrollee's residence or the death of the enrollee.

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- Prompt notification to the State when information is received about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement.

- Verification, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

- All employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws, including information about rights of employees to be protected as whistleblowers per section 1902(a)(68) of the Social Security Act.

- The prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the State's program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

- The Contractor's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud per 42 CFR 455.23.

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, 42 CFR 455.14, and 42 CFR 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), 42 CFR 438.604(a)(7), and 42 CFR 438.606, the Contractor shall report annually to the State on the recoveries of overpayments. In accordance with 42 CFR 438.608(d)(1)(ii)-(iii), the Contractor must have a process, timeframes, and documentation required for reporting the recovery of all overpayments and

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for payment of recoveries in situations where the Contractor is not permitted to retain some or all of the recovery.

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.

The Contractor will have policies and procedures in place to fully comply with 42 CFR 438.608. 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. The Contractor or subcontractor with delegated responsibility for coverage of services and payment of claims, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state per 42 CFR 438.608(a)(2).

The Contractor must maintain relevant documentation for a minimum of seven (7) years. In accordance with 42 CFR 438.608(d)(1)(i), the Contractor shall have retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. Quarterly and annual reporting of recoveries will be made in accordance with the guidance in the MCE Reporting Manual.

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.

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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 2A.

8.6 Long Term Services and Supports

In addition to the requirements in this section, the Contractor shall:

- As part of monitoring, auditing and investigating network providers and subcontracted services to detect fraud, abuse and improper payments, have mechanisms in place to review documentation maintained by providers of LTSS to ensure compliance with the billing requirements.

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- Ensure that 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, that the Contractor will 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, 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.

- Have provisions in its Compliance Plan regarding instructions to Hospice, 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 personal care and hospice providers to ensure providers are only audited by one MCE. The results of the audits will be submitted annually to FSSA with the Compliance Plan.

- Assess provider adherence to all State and federal Medicaid regulations.

9.0 Information Technology (IT) Systems

The Contractor must have an Information Technology (IT) system sufficient to support the PathWays 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(a), 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. The Contractor must be capable of collecting data on enrollee and provider characteristics as specified by the State and on all services furnished to enrollees through an encounter data system as required by 42 CFR 438.242(b)(2).

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.

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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 45 CFR 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 438.242(b)(4). In accordance with 42 CFR 438.600-610, 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

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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 process 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:

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- 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

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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 - Administrative Safeguards. Contingency plans shall be consistent with the standards identified in the NIST 800-34 guidelines. 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. The Contractor must 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

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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 PathWays 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

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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 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

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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. In accordance with 42 CFR 438.608(c)(3), 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. 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 PathWays Policies and Procedures Manual.

9.6 Health Information Technology and Interoperability

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 Application Programming Interfaces (APIs) and payer to payer data exchanges. Contactors are also required to implement and maintain systems that meet Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B.

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EXHIBIT 1.A

SCOPE OF WORK - INDIANA PATHWAYS FOR AGING

The Contractor must implement and maintain a publicly accessible standards-based API as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438(10)(h)(1) and (2) per 42 CFR 438.242(b)(6). In accordance with 42 CFR 438.242(b)(5) and 42 CFR 457.1233(d), the Contractor shall implement APIs that allow:

- Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

- Encounter data, including encounter data from any network provider the Contractor is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors no later than one (1) business day after receiving the data from providers;

- Clinical data, including laboratory results, if the Contractor maintains any such data, no later than one (1) business day after the data is received by the State; and

- Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information.

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;

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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 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.

In accordance with 42 CFR 438.242(b)(3)(i)-(iii), the Contractor must:

- Collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts;

- Screen the data received from providers for completeness, logic, and consistency; and

- Verify the accuracy and timeliness of data reported by providers, including data from network providers the Contractor is compensating on the basis of capitation payments.

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,

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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 PathWays. 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 helps 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.

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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 9.7.6. The Contractor shall offer provider participation in testing and auditing for accurate payment to LTSS providers.

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. It is the responsibility of the Contractor to ensure claims systems are configured to adjudicate claims using the most current information provided by the State and/or CMS. When the Contractor inappropriately denies or inappropriately pays an incorrect rate, the Contractor must expedite the reprocessing of those claims within 15 business days. The Contractor shall have processes in place to adequately adjudicate claims and make claims payments within this timeframe.

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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's 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)-(6), 42 CFR 447.46(c), and sections 1902(a)(37)(A) and 1932(f) of the Social Security Act, 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, with the exception of HCBS claims. The MCE must pay HCBS related electronically filed clean claims within seven (7) business 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

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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. 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 ninety (90) calendar days 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 6.9, 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 into their claim processing systems. New fee schedules or fee schedule updates should be loaded into their claim systems within 30 days of receipt from the State. The Contractor shall have all Medicaid rate updates prepared for implementation on the effective date chosen by the State. 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 2A 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:

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- 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 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 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

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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.

9.7.7 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.

9.7.8 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).

In accordance with 42 CFR 438.242(c)(1)-(4) and 42 CFR 438.818, the Contractor must provide for:

- Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees;
- Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State based on program administration, oversight, and program integrity needs;
- Submission of all enrollee encounter data, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR 438.818; and
- Specifications for submitting encounter data to the State in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate.

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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 per 42 CFR 438.604(a)(1), 42 CFR 438.606, and 42 CFR 438.818.(a)(2)-(3). 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 PathWays 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 PathWays program and to the Contract. In accordance with 42 CFR 438.604(a)(2), 42 CFR 438.606, 42 CFR 438.3, and 42 CFR 438.5(c), the Contractor's submitted data shall be the basis of which the State certifies the actuarial soundness of capitation rates to the Contractor, including base data that is generated by the Contractor. 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 2A for a schedule of liquidated damages that FSSA will assess for non-compliance with encounter data submission requirements.

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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. Per 42 CFR 438.3(s)(2), all drug utilization data that is necessary for the State to bill manufacturers for rebates must be submitted to the State no later than forty-five (45) calendar days after the end of each quarterly rebate period. 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 2A 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.

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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 twenty-one (21) 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.

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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 45 CFR 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. 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 per 42 CFR 438.3(t).

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.

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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 health 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. Per 45 CFR 144.103, health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

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 health 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.

To increase overall provider participation in the IHCP, the Centers for Medicare & Medicaid Services (CMS) exempts certain medical services from the cost avoidance requirement. Providers are allowed to bill some claims to the IHCP first, even when TPL is present for the member.

Home- and Community-Based Services (HCBS), Money Follows the Person (MFP), and Medicaid Rehabilitation Option (MRO) claims are exempt from TPL cost avoidance requirements. The Contractor will not bill private insurance carriers through the TPL or reclamation processes for claims containing benefit modifier codes for the following benefit plans:

- Adult Mental Health Habilitation (AMHH)
- PathWays Waiver
- PathWays MFP Demonstration Grant (PathWays MFP)
- Behavioral and Primary Healthcare Coordination (BPHC)
- Child Mental Health Wraparound (CMHW)
- Community Integration and Habilitation Waiver (CIH Waiver)

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- Community Integration and Habilitation MFP Demonstration Grant (CIH MFP)
- Family Supports Waiver (FSW)
- Medicaid Rehabilitation Option (MRO)
- Traumatic Brain Injury Waiver (TBI Waiver)
- Traumatic Brain Injury MFP Demonstration Grant (TBI MFP)

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, 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 CFR 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

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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 PathWays. 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). Reporting requirements for the Contractor's D-SNP are outlined in the D-SNP Reporting Manual as required in the aligned D-SNP's SMAC. 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 contained in this contract. The Contractor shall submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the State or Secretary per 42 CFR 457.1285, 42 CFR 438.604(b) and 42 CFR 438.606(b). 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(a)-(b) 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.

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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 2A 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;
- Key Staff and Other Staffing; and
- Audited Financial Report.

On an annual basis and in accordance with 42 CFR 438.3(m), the Contractor must submit program specific audited financial reports, separate for each managed care program (i.e., HIP, Hoosier Healthwise, Hoosier Care Connect, and PathWays as applicable). The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. 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 158.150.

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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 detailed 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.

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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 PathWays 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). The Contractor shall submit this data in the timeframe specified by FSSA. The Contractor shall cooperate with OMPP in meeting all required Indiana PathWays for Aging reporting activities as required by CMS. The Contractor agrees to submit data for the Indiana PathWays for Aging quarterly and annual reports to OMPP in a timeframe and format as set forth in the Indiana PathWays for Aging Reporting Manual. For any reports not specifically set forth in the MCE Reporting Manual, the State will request any such reporting and data requests directly to the Contractor.

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 2A, 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 2A. 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

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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 438.708 or has failed to meet the applicable requirements of 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

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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 438.708 and 42 CFR 438.710(b). In accordance with 42 CFR 438.710(b)(2), 42 CFR 438.722, section 1932(e)(4) of the Social Security Act and 42 CFR 438.10, the State will:

- Give the Contractor a written notice of its intent to terminate and the reason for the termination;
- Provide the Contractor with the time and place of the pre-termination hearing;
- Provide the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract;
- Provide the effective date for Contract termination when decisions are affirmed;
- Give the enrollees of the Contractor notice of the State's intent and actual termination; and
- Inform enrollees of their options to disenroll immediately without cause and for receiving Medicaid services following the effective dates of termination.

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

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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.

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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.

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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

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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

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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 438.310-370, 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 an event, seek and obtain actual damages.

The remedies available to the State under this Agreement include but are not limited to:

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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 PathWays program 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 PathWays 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.

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EXHIBIT 2.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Except as defined below or where the context requires otherwise, all capitalized terms shall have the meanings ascribed to them in the Contract.

Note that a previous version of this Exhibit exists that relates specifically to July 1, 2024 to June 30, 2025. The specific final requirements for this specified period, will regulate the requirements and calculations applied to this previous period, unless changes specifically addressing this previous period are made.

A. Contract Compliance

1. Non-compliance Remedies

It is the State's primary goal to ensure that the Contractor and its subcontractors/vendors deliver quality care to members while maintaining the program integrity of the State of Indiana's PathWays for Aging Program (PathWays). To assess the attainment of this goal, the State monitors certain quality and performance standards, and holds the Contractor accountable for being in compliance with Contract terms. FSSA accomplishes this by working collaboratively with the Contractor to maintain and improve programs, and not to impair Contractor stability.

In the event the Contractor and/or its subcontractors/vendors fails to meet performance requirements or reporting standards set forth in the Contract or other standards established by the State, the State will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies discussed below or in this Contract. The State will provide written notice of non-compliance to the Contractor within sixty (60) calendar days of the State's discovery of such non-compliance. The State will provide the Contractor with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains the basis and nature of the sanction and will include any appeal rights the State elects to provide, in accordance with 42 CFR 438.710(a)(1)-(2).

If FSSA elects not to exercise a corrective action clause contained anywhere in the Contract in a particular instance, this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the Contract, may be retroactively assessed.

2. Corrective Actions

In accordance with 42 CFR 438, Subpart I, FSSA may require corrective action(s) when the Contractor has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The written notice of non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, any of the following:

A. Written Warning: FSSA may issue a written warning and solicit a response regarding the Contractor's corrective action.

B. Formal Corrective Action Plan: FSSA may require the Contractor to develop a formal corrective action plan to remedy the breach. The corrective action plan must be submitted under the signature of the Contractor's chief executive and must be approved by FSSA. If the corrective action plan is not acceptable, FSSA may provide suggestions and directions to bring the Contractor into compliance.

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C. Withholding Full or Partial Capitation Payments: FSSA may suspend capitation payments for the following month or subsequent months when the State determines that the Contractor is materially non-compliant. FSSA must give the Contractor written notice ten (10) business days prior to the suspension of capitation payments and specific reasons for non-compliance that result in suspension of payments. The State may continue to suspend all capitation payments until CMS, or the State are satisfied that non- compliance issues are corrected and not likely to reoccur.

D. Suspending Auto-assignment: FSSA may suspend auto-assignment of members to the Contractor. The State may suspend all auto-assignment or may selectively suspend auto-assignment for a region or county. The State will notify the Contractor in writing of its intent to suspend auto- assignment at least ten (10) business days prior to the first day of the suspension period. The suspension period may be for any length of time specified by the State. The State will base the duration of the suspension upon the nature and severity of the default and the Contractor's ability to cure the default.

E. Granting Members the Right to Disenroll Without Cause: The State may permit members the right to disenroll from the Contractor without cause.

F. Suspending All New Enrollments: The State may suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

G. Assigning the Contractor's Membership and Responsibilities to Another Contractor: The State may assign the Contractor's membership and responsibilities to one (1) or more other Contractors that also provide services to the PathWays population, subject to consent by the Contractor that would gain that responsibility. The State must notify the Contractor in writing of its intent to transfer members and responsibility for those members to another Contractor at least ten (10) business days prior to transferring any members. This option also includes permitting members the right to disenroll from the reassigned Contractor without cause.

H. Appointing Temporary Management of the Contractor's Plan: The State may assume management of the Contractor's plan or may assign temporary management of the Contractor's plan to the State's agent in accordance with 42 CFR 438.706(a) and Section 1932 (e)(2)(B)(1) of the Social Security Act. Temporary management may be imposed if at any time the State determines that there is continued egregious behavior by the Contractor, there is substantial risk to enrollees' health, or the sanction is necessary to ensure the health of the Contractor's enrollees in one of two circumstances: while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the Contractor**.** Temporary management will be imposed when the Contractor repeatedly fails to meet substantive requirements in section 1903(m) or 1932 of the Social Security Act or 42 CFR 438. The State may not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines that the Contractor can ensure the sanctioned behavior will not reoccur per 42 CFR 438.702 and Section 1932 (e)(2)(B)(ii) of the Social Security Act. If the State imposes temporary management because the Contractor has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438, the State will notify affected enrollees of their right to terminate enrollment without cause in accordance with 42 CFR 438.706(b).

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I. Contract Termination: The State reserves the right to terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any term or condition of this Contract, or failure to take corrective action as required by FSSA to comply with the terms of this Contract. The State must provide thirty (30) calendar days written notice and must set forth the grounds for termination.

The State may impose additional sanctions provided for under State statutes or regulations to address noncompliance per 42 CFR 438.702(b).

3. Liquidated Damages

In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Contract, or other standards set forth by the State, it is agreed that damages shall be sustained by the State, and the Contractor shall pay to the State liquidated damages pursuant to this contract, its actual damages, and/or penalties as expressly permitted under 42 USC Chapter Seven, Subchapter XIX, Section 1396u-2 (e).

It is agreed that in the event of a failure to meet specified performance or reporting requirements subject to liquidated damages, it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the State will sustain in the event of, and by reason of, such failure; it is therefore agreed that the Contractor will pay the State for such failure according to the following subsections. No punitive intention is inherent in the following liquidated damages provisions.

FSSA may impose remedies resulting from failure of the Contractor to provide the requested services depending on the nature, severity, and duration of the deficiency. In most cases, liquidated damages will be assessed based on this Exhibit. Should FSSA choose not to assess damages for an initial infraction or deficiency, it reserves the right to require corrective action or assess damages at any point in the future.

The State shall notify Contractor of liquidated damages due, and Contractor shall pay the State the full amount of liquidated damages due within ten (10) business days of receipt of the State's notice. The State may, in its sole discretion, elect at any time to offset any amount of liquidated damages due against capitation payments otherwise due Contractor pursuant to the Contract.

In the event liquidated damages are imposed under the Contract, the Contractor must provide FSSA with a formal corrective action plan, as well as monthly reports on the relevant performance metrics until such time as the deficiency is corrected for a period determined by the State.

4. Non-compliance with Reporting Requirements

The MCE Reporting Manual, distributed following the Contract award and periodically thereafter, details the required formats, templates and submission instructions for the reports listed in the Contract. FSSA may change the frequency of required reports, or may require additional reports, at FSSA's discretion. The Contractor will be given at least thirty (30) calendar days' notice of any change to reporting requirements.

If the Contractor's non-compliance with the reporting requirements impacts the State's ability to monitor the Contractor's solvency, and the Contractor's financial position requires the State to transfer members to another Contractor, the State will require the Contractor to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement Contractor

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as a result of member transfer. In addition, the Contractor must pay any costs the State incurs to accomplish the transfer of members. Further, FSSA will withhold all capitation payments or require corrective action until the Contractor provides satisfactory financial data.

5. Performance and Reporting Requirements

Minimum recommended sample sizes for Hybrid and Survey measures must be met. Any report which requires a minimum sample size (e.g., CAHPS, HEDIS) will be rejected if they do not meet the established minimum standards for sampling. If Contractor fails to submit any report by the required deadline or fails to utilize the required sample sizes, the Contractor may forfeit eligibility for participation in the pay for outcomes program as described in Section B of this Exhibit and the Contractor will be subject to corrective actions as set forth in Section A.2 of this Exhibit.

If Contractor fails to submit any report required in the Contract, MCE Reporting Manual, or D-SNP Reporting Manual in a timely, complete, and accurate manner, Contractor shall pay liquidated damages of five hundred dollars ($500) per day per report. On the third business day that a report is late, the Contractor shall pay five thousand, two hundred dollars ($5,200) per report per month until a complete and accurate report is submitted to the State.

Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate reports required under the Contract.

6. Encounter Data Quality (previously CRCS) Report

FSSA recognizes the importance of monitoring Contractor performance throughout the calendar year, and Contractor will be required to submit quarterly Encounter Data Quality reports for validation to FSSA in a timely, complete, and accurate manner for the PathWays program in accordance with the reporting manual. Each quarterly report must include year-to-date information and must be verified to a degree of at least ninety-eight percent (98%) completeness for all claims (i.e., an incompleteness rate of no more than 2.0%). To the extent Encounter Data Quality data or underlying encounter data is used in a public report, it must be received by the stated deadline in order to be published.

FSSA will use Contractor's encounter data, or other method of data completion verification deemed reasonable by FSSA, to verify the completeness of the Encounter Data Quality reports in comparison to Contractor's encounter claims. FSSA reserves the right to change the method of data completion verification upon reasonable advance notice to the Contractor.

The Reporting Manual details the requirements for submission of Encounter Data Quality reports. No liquidated damages apply to Encounter Data Quality reporting the first year of the contract. However, FSSA reserves the right to impose remedies including liquidated damages in subsequent years.

7. Non-compliance with Encounter Claims Submission Requirements

Payment of liquidated damages as outlined below does not relieve Contractor of its responsibility to provide complete and accurate shadow/encounter claims required under the Contract.

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EXHIBIT 2.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

a. Weekly Batch Submission

The Contractor must submit at least one (1) batch of encounter data for paid and denied institutional, professional, and pharmacy claims in a standardized secure format, as specified by FSSA on a weekly basis. If, during any calendar month, Contractor fails to submit all encounter claims on a weekly basis when due, unless delay is caused by technical difficulties of FSSA or its designee, Contractor will pay liquidated damages in the amount of four thousand, eight hundred fifty dollars ($4,850) for each claim type for which shadow/encounter claims were not submitted in a timely manner.

b. Pre-cycle Edits

For each weekly encounter claims batch submission, Contractor must achieve no less than a ninety-seven percent (97%) compliance rate with pre-cycle edits. The State will assess pre-cycle edit compliance based upon the average compliance rate of the weekly encounter claims batch submissions made during the calendar month and will calculate compliance separately for institutional, professional and pharmacy claims. If the average compliance rate is below ninety- seven percent (97%) for any type of encounter claim, Contractor will pay liquidated damages in the amount of five thousand, four hundred sixty dollars ($5,460) for each deficient encounter claim type. For purposes of this section there are three (3) encounter claim types: institutional, professional and pharmacy. Payment of liquidated damages does not relieve Contractor of its responsibility to provide complete and accurate encounter claims required under the Contract.

c. Prescription Drug Rebate File

Contractor shall comply with the required layouts for submitting pharmacy claim extracts used to support federal drug rebate invoicing and collection. The frequency of file submissions and the content of the files supporting drug rebate invoicing and collection are defined by FSSA and pertain to all pharmacy claim transactions and medical claim transactions that contain physician administered drugs as set forth in The Scope of Work. Contractor shall provide this reporting to FSSA in the manner and timeframe prescribed by FSSA, including, but not limited to, through a rebate file to the State or its designee. For any instance in which the Contractor fails to provide required files for drug rebate purposes in a timely, accurate, or complete manner, the Contractor shall be responsible for interest, based on the interest calculation for late rebate payments methodology published by CMS, on delayed rebate money owed to the State. For example, if the Contractor fails to meet the FSSA established deadline for submission of the claim extracts and/or rebate file and the drug rebate contractor completes the quarterly drug rebate invoicing process without the Contractor's claim information for the invoicing quarter, the Contractor shall reimburse the State for interest on the rebate amount later calculated by the drug rebate contractor, for the period of delay in collecting the rebate amount. Such reimbursement shall be due within thirty (30) days of presentation of the interest calculation.

SUPDL Compliance Report The Contractor shall make all appropriate efforts to meet SUPDL adherence expectations for the Contract Year as set and if directed by FSSA, including but not limited to targets for specific classes. FSSA shall provide the Contractor with such SUPDL adherence targets at least annually. Such adherence targets may change during the Contract Year.

FSSA shall calculate, for SUPDL adherence targets, at least quarterly, whether

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the Contractor is on track to meet adherence targets for the Contract Year and provide the Contractor with a report showing the results.

FSSA annually shall calculate whether the Contractor met SUPDL adherence targets for the Contract Year and provide the Contractor with a report showing the results.

For SUPDL adherence calculations, FSSA shall use Encounter Data to determine the ratio of claims for Preferred products paid by the Contractor compared to claims for all products paid by the Contractor. The SUPDL calculation may be done at the therapeutic class level and be normalized for day supply.

If Contractor fails to meet SUPDL adherence targets, FSSA may assess a penalty equal to the number of prescriptions outside the target range times the average differential in rebate between a preferred product and a non-preferred product.

8. Network Access

If FSSA determines that the Contractor has not met the network access standards established in the Contract, FSSA shall require submission of a Corrective Action Plan to FSSA within ten (10) business days following notification by the State. Determination of failure to meet network access standards shall be made following a review of the Contractor's Network Geographic Access Assessment Report. The frequency of required report submission will be outlined in the Reporting Manual. Contractor will pay liquidated damages in the amount of five thousand, two hundred, and fifty dollars ($5,250) for each reporting period that the Contractor fails to meet the network access standards. Upon discovery of noncompliance, the Contractor shall be required to submit monthly Network Geographic Access Assessment Reports until compliance is demonstrated for sixty (60) consecutive days. FSSA may also require the Contractor to maintain an open network for the provider type for which the Contractor's network is non-compliant. Further, should Contractor be out of compliance for three (3) consecutive months as a result of failure to meet network access standards, FSSA shall immediately suspend auto- enrollment of members with the Contractor, until such time as Contractor successfully demonstrates compliance with the network access standards.

9. Marketing Violations

Per 42 CFR 438.704(b)(1), if the Contractor distributes marketing materials that have not been approved by the State or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, the State may impose a civil monetary penalty of up to $25,000 for each such distribution.

10. Member and Provider Communication and Education Violations

Per 42 CFR 438.704(b)(1), if the Contractor misrepresents or falsifies information that it furnishes to a member, potential enrollee, or health care provider, the State may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation. In addition, FSSA reserves the right to require an immediate retraction or correction by the Contractor in a format acceptable to FSSA. For illustration purposes only, a violation will be determined to exist if Contractor promulgated or distributed, directly or indirectly through any agent or independent contractor, member and/or provider communication or education materials that have not been approved by FSSA or those that have been approved by FSSA that Contractor identifies that contain

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inaccurate, false, or misleading information. For further illustration, a violation will be determined to exist if the Contractor distributes any member or provider communication, including member or provider letters, bulletins, alerts, press releases or other press communications, bulletins and forms without prior approval by FSSA. For purposes of this Exhibit, provider communications are limited to provider communications related to the PathWays program.

11. Claims Payment

If Contractor fails to pay or deny ninety-eight percent (98%) or more of any type of clean claims within the required timeframe, Contractor shall pay liquidated damages in the amount of five thousand, seven hundred dollars ($5,700) for each deficient claims type. For the purposes of this section, there are six (6) claim types: professional paper claims, professional electronic claims, facility paper claims, facility electronic claims, pharmacy paper claims, and pharmacy electronic claims.

12. Provider Claim Disputes

Contractor must resolve and respond to ninety-nine percent (99%) of provider informal claim disputes within thirty (30) calendar days of receipt of the dispute. The Contractor must resolve and respond to ninety-nine percent (99%) of provider formal disputes within forty-five (45) calendar days of the receipt of the dispute. For each quarter in which Contractor fails to provide and communicate a timely resolution on ninety-nine percent (99%) of informal and/or formal disputes, Contractor shall pay liquidated damages in the amount of two thousand, three hundred and ten dollars ($ 2,310).

13. Readiness Review

If Contractor fails to satisfactorily pass the readiness review at least thirty (30) calendar days prior to scheduled member enrollment (or other deadline as may be established at the sole discretion of the State), the State may delay member enrollment and/or may require other remedies (including, but not limited to contract termination), and Contractor shall be responsible for all costs incurred by the State as a result of such delay.

In addition, for each business day that Contractor fails to submit readiness review processes beyond their expected due date, Contractor shall pay liquidated damages in the amount of five thousand, four hundred and fifty dollars ($5,450). Damages will be assessed each time the requirements are not met. In each instance that Contractor fails to submit substantially complete and accurate readiness review responses, Contractor shall pay liquidated damages in the amount of three thousand, fifty dollars ($3,050).

14. Member/Provider Helpline and Website Services

There are twelve (12) separate measures that will equally apply to the PathWays Member/Provider Helpline and Website Metrics and the Pharmacy Helpline and Website Metrics Reports. For each instance in which FSSA finds the Contractor has failed to meet a metric for a given quarter, the Contractor shall pay liquidated damages in the amount of one thousand, four hundred seventy dollars ($1,470) per quarter of non-compliance for each metric.

Helpline and Website Metrics: The twelve (12) metrics are as follows:

i. For any calendar month, at least ninety-seven percent (97%) of all phone calls to the Helpline must reach the call center menu

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within thirty (30) seconds or the prevailing benchmark established by NCQA.

ii. For any calendar month, at least eighty-five percent (85%) of all phone calls to an approved automated Helpline must be answered by a Helpline representative within thirty (30) seconds after the call has been routed through the call center menu. Answered means that the call is picked up by a qualified Helpline staff person.

iii. 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.

iv. If 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.

v. For any calendar month, the busy rate associated with the Helpline shall not exceed zero percent (0%).

vi. Hold time shall not exceed one (1) minute in any instance, or thirty (30) seconds, on average.

vii. For any calendar month, the lost call (abandonment) rate associated with the Helpline shall not exceed five percent (5%).

viii. Contractor must maintain an answering machine, voice mail system or answering service to receive calls to the Helpline that take place after regular business hours. For any calendar month, one hundred percent (100%) of all after hours calls received must be returned or attempted to be returned within one (1) business day.

ix. Contractor must maintain a system to receive and address electronic inquiries via e-mail and through the member website. For any calendar month, one hundred percent (100%) of all electronic inquiries received must be responded to within one (1) business day.

x. Contractor's Helpline for one hundred percent (100%) of operating hours must be properly equipped to accept calls including, without limitation, calls from members with limited English proficiency and calls from members who are deaf, hearing impaired or have other special needs.

xi. For any calendar month, eighty-five percent (85%) of all calls to the Helpline must be resolved during the initial call.

xii. Contractor must make pertinent information available to members and providers through an internet website in an FSSA-approved

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format in accordance with the terms of the Contract. The website must be available for access by members no less than twenty-three and one-half (23.5) hours per day on average.

15. Prior Authorization

Contractor must respond to requests for authorization of services in the format and within the timeframes set forth in the Contract. For each quarter in which the Contractor fails to adjudicate ninety- eight percent (98%) or more of prior authorization requests within the required timeframes, Contractor shall pay liquidated damages in the amount of six thousand, six hundred and fifteen dollars ($6,615).

16. Member Grievances

Contractor must resolve one hundred percent (100%) of member grievances within thirty (30) calendar days of receipt of the grievance. For each quarter in which Contractor fails to provide and communicate a timely resolution on one hundred percent (100%) of member grievances, Contractor shall pay liquidated damages in the amount of three thousand, one hundred and fifty dollars ($3,150).

17. Member Appeals

Contractor must resolve one hundred percent (100%) of member appeals within thirty (30) calendar days of receipt of the appeal. For each quarter in which Contractor fails to provide and communicate a timely resolution on one hundred percent (100%) of member appeals, Contractor shall pay liquidated damages in the amount of two thousand, three hundred and ten dollars ($2,310). The Contractor must also provide a timely and satisfactory response to documentation required to facilitate member appeals in accordance with the FSSA fair hearing process. In addition, the Contractor shall provide a representative to participate in the FSSA fair hearing process to represent the State. For each instance in which the Contractor fails to either (i) provide a timely response to documentation required for the member appeal within the time frames set forth by FSSA, or (ii) upon adequate notice, represent the State at the FSSA fair hearing, Contractor shall pay liquidated damages in the amount of one thousand, one hundred dollars ($1,100).

18. Provider Credentialing

Contractor shall process all credentialing applications within thirty (30) calendar days of receipt of a complete application. If FSSA determines that the Contractor has not processed all credentialing applications in a timely manner, FSSA shall require submission of a formal Corrective Action Plan within ten (10) business days following notification by the State. Upon discovery of noncompliance, Contractor shall be required to submit monthly provider credentialing reports until compliance is demonstrated for sixty (60) consecutive days.

19. Complaints and Internet Quorum Inquiries

The Contractor must resolve complaints and Internet Quorum (IQ) inquiries to FSSA's satisfaction, within the timeframes set forth by FSSA. Unless an alternative deadline is identified by FSSA for a specific IQ inquiry, IQ inquiries must be resolved in no more than five (5) business days. The Contractor may request additional time to respond but FSSA is under no obligation to grant extensions. For each instance in which the Contractor fails to provide a timely or accurate response to complaints or IQ inquiries within the timeframes set forth by FSSA, Contractor shall pay liquidated

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damages in the amount of four hundred dollars ($400.00).

20. Notification of System Outages

Contractor shall notify FSSA, at minimum, within two (2) hours of discovery of a disaster or other disruptions in its normal business operations. Contractor will be subject to corrective actions as set forth in Section A.2 of this Exhibit for failure to provide notification within two (2) hours of discovery.

21. Restoring Operations Following a Disaster

Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data, and software at an existing or alternate location under emergency conditions within twenty-four (24) hours of identification of a disaster. If the Contractor's failure to restore operations requires the State to transfer members to another Contractor, to assign operational responsibilities to another Contractor or the State is required to assume the operational responsibilities, the State will require the Contractor to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement Contractor. In addition, the Contractor must pay any costs the State incurs associated with the Contractor's failure to restore operations following a disaster, including but not limited to costs to accomplish the transfer of members or reassignment of operational duties.

22. Advanced Notice of System Upgrades and Replacements

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 and at least ninety (90) calendar days prior to the installation or implementation of major software or hardware changes, upgrades, modifications, or replacements as defined in Section 9.0 of the Scope of Work. Contractor will be subject to corrective actions as set forth in Section A.2 of this Exhibit for failure to provide advanced notice in the required timeframe and may be required to delay implementation of the planned upgrade, modification, or replacement.

23. Health Insurance Portability and Accountability Act (HIPAA) and Security Breaches

Contractor shall notify FSSA within one (1) business day upon discovery of a HIPAA, 42 CFR Part 2, or other security breach. Contractor shall be subject to corrective actions as set forth in Section A.2 of this Exhibit for failure to provide advanced notice in the required timeframe and must pay any costs the State incurs as a result of the violation.

24. Plan Solvency

If Contractor fails to meet solvency performance standards set forth below and as may be amended by the State, Contractor shall be subject to corrective actions as set forth in the Contract, including but not limited to Contract termination.

a. On a quarterly basis, the current ratio (assets to liability) shall be greater than or equal to one (1).

b. On a quarterly basis, the number of days' cash on hand shall not be fewer than sixty (60) business days. FSSA reserves the right to adjust the required number of days of cash on hand based on

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historical Contractor performance and the ability of the Contractor to demonstrate solvency.

c. On a quarterly basis, days in unpaid claims shall not be greater than sixty-five (65) business days.

d. On a quarterly basis, days in claims receivable shall not be greater than thirty (30) business days.

e. On a quarterly basis, equity (net worth) shall be maintained at or above $150 per member.

25. Non-compliance with General Contract Provisions

The objective of this requirement is to provide the State with an administrative procedure to address issues where the Contractor is not compliant with the Contract. Through routine monitoring, the State may identify Contract non-compliance issues. If this occurs, the State will notify the Contractor in writing of the nature of the non-performance issue. The State will establish a reasonable period of time, but not more than ten (10) business days, during which the Contractor must provide a written response to the notification. If the Contractor does not correct the non-performance issue within the specified time, the State may enforce any of the remedies listed in this Exhibit.

Specifically, the State may enforce any of the remedies listed if the Contractor does the following:

- Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Contract with the State, to a member (note that per 42 CFR 438.704(b)(1), the State may impose a civil monetary penalty of up to $25,000 for each failure to provide services, as well as enforcing any of the remedies listed in Section A.2 above);

- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the PathWays program, note that per 42 CFR 438.704(c), the State may impose a civil monetary penalty of up to $25,000 or double the amount of the excess charges (whichever is greater), as well as enforcing any of the remedies listed in Section A.2 above);

- Acts to discriminate among members on the basis of their health status or need for health care services, such as unlawful termination or refusal to re-enroll a member or engaging in any practice that would reasonably be expected to discourage enrollment by a potential enrollee whose medical condition or history indicates probable need for substantial future medical services (note that per 42 CFR 438.704(b)(2) and (3), the State may impose a civil monetary penalty of up to $100,000 for each determination of discrimination, the State may impose a civil monetary penalty of up to $15,000 for each individual the Contractor did not enroll because of a discriminatory practice, up to the $100,000 maximum, and/or enforce any of the remedies listed in Section A.2 above);

- Misrepresents or falsifies information that it furnishes to CMS or to the State (note that per 42 CFR 438.704(b)(2), the State may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation, as well as enforcing any of the remedies listed in Section A.2 above);

- Misrepresents or falsifies information that it furnishes to a member, potential

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enrollee, or health care provider (note that per 42 CFR 438.704(b)(1), the State may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation, as well as enforcing any of the remedies listed in Section A.2 above);

- Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210 (note that per 42 CFR 438.704(b)(1), the State may impose a civil monetary penalty of up to $25,000 for each failure to comply, as well as enforcing any of the remedies listed in Section A.2 above);

- Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

26. FSSA Required Trainings

The Contractor shall ensure that any MCE staff member given an FSSA email completes all FSSA required trainings. Unless an alternative deadline is identified by FSSA for a specific training, all FSSA required trainings must be completed by its respective due date. The Contractor may request additional time to complete but FSSA is under no obligation to grant extensions.

27. Other Non-Performance

If the Contractor fails to meet the other performance standards set forth in the Contract, Contractor will be subject to corrective actions as set forth in the Contract.

28. Corrective Action Plan Response

If the Contractor fails to provide a timely and acceptable corrective action plan or comply with corrective action plans as required by the State, Contractor shall pay liquidated damages in the amount of four hundred dollars ($400) per day for a late corrective action plan response, two thousand, three hundred and ten dollars ($2,310) for failure to provide an acceptable corrective action plan response, and four hundred dollars ($400) per day for failure to comply with an accepted corrective action plan response.

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B. Pay for Outcomes Program

1. Program Establishment and Eligibility

FSSA has established a pay for outcomes program under which Contractor may receive additional compensation if certain conditions are met. The state encourages plans to share earned incentive payments with members and providers. The compensation under the pay for outcomes program is subject to Contractor's complete and timely satisfaction of its obligations under the Contract. This includes but is not limited to timely submission of the Contractor's HEDIS Report for the measurement year and the Certified HEDIS Compliance Auditor's attestation listed in Section A.5 of this Exhibit. This includes reports as required and defined by the State. In furtherance of the foregoing and not by limitation, the Contractor may, in FSSA's discretion, lose eligibility for its compensation under the pay for outcomes program if:

i. FSSA has suspended, in whole or in part, capitation payments or enrollment to the Contractor;

ii. FSSA has assigned, in whole or in part, the membership and responsibilities of Contractor to another participating managed care plan contractor;

iii. FSSA has assumed or appointed temporary management with respect to the Contractor;

iv. The Contract has been terminated;

v. The Contractor has, in the determination of the Director of the Office of Medicaid Policy and Planning, failed to execute a smooth transition at the end of the Contract term, including failure to comply with the Contractor responsibilities set forth in the Scope of Work; or

vi. Pursuant to the Contract including without limitation this Exhibit, FSSA has required a corrective action plan or assessed liquidated damages against Contractor in relation to its performance under the Contract during the measurement year.

FSSA may, at its option, reinstate Contractor's eligibility for participation in the pay for outcomes program once Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract, and FSSA has satisfactory assurances of acceptable future performance.

2. Incentive Payment Potential

During each measurement year, FSSA will withhold a portion of the approved capitation payments from Contractor as follows:

- Calendar Year 2024 – one point eight five percent (1.85%)
- Calendar Year 2025 – one point eight five percent (1.85%)
- Calendar Year 2026 – two percent (2%)
- Calendar Year 2027 – two point one five percent (2.15%)
- Calendar Year 2028 – two point one five percent (2.15%)

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- Calendar Year 2029 – two point two five percent (2.25%)
- Calendar Year 2030 – two point two five percent (2.25%)

Contractor may be eligible to receive some or all of the withheld funds based on Contractor's performance in the areas outlined in Section B.3 of this Exhibit. The State reserves the right to adjust performance measures and targets in future Contract years.

3. Calendar Years 2025/2026 Outcome Measures and Incentive Payment Structure (July 1, 2025 to June 30, 2026)

The outcome measures, targets, and incentive payment opportunities for calendar years 2025/2026 are set forth below. The measurement time period for incentive payment opportunities will be July 1, 2025 to June 30, 2026. The performance measures and targets are based on the priority areas established by FSSA. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. Note that if a performance measure is retired during the course of a year, the State, at its sole discretion and in consultation with the Contractor, may replace the performance measure for that performance period. The performance measures and targets applicable during subsequent years of the Contract shall be established annually by FSSA and reflected in an amendment to the Contract.

Contractor performance shall be calculated based on care delivered during calendar years 2025/2026. The State reserves the right to make incentive payments, for any measure, be conditioned upon Contractor substantially maintaining or improving Contractor's outcome on that individual measure from the previous year. If the State exercises this right, the Contractor will be eligible for incentive payments if Contractor outcomes on individual measures for a certain year decline from the previous year's outcomes by a de minimis amount defined by FSSA for each measure. Future incentive payments for any measure may be conditioned upon Contractor maintaining or improving Contractor's outcome from the prior year.

Measures will be paid based on custom specifications and performance will be determined by FSSA or its designee. Contractor shall submit information to FSSA, in the format and detail specified by FSSA, with respect to each performance measure set forth below. Any data received after the required submission date will not be eligible for an incentive payment.

Incentive payments are payable in the form of release of funds withheld. For purposes of this subsection only, the amount withheld shall be referred to as the "Performance Withhold." The amount of the Performance Withhold at risk varies by measure.

Total Amount of Withhold at Risk (July 1, 2025 to December 31, 2025): 1.85%
Total Amount of Withhold at Risk (January 1, 2026 to June 30, 2026): 2%

Indiana PathWays for Aging Pay for Outcome Measure 1	
Pay for Outcome Measure	Care and Service Coordination Caseload Excellence
Pay for Outcome Sub Measure (if any)	N/A
Brief Description	Percentage of complex case managers, care coordinators, and service coordinators whose average monthly caseload are less than 100 caseload points.
Percentage of Withhold at Risk	**Total 40%**

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i. ***Measure: Care and Service Coordination Caseload Excellence*.** Administrative reporting based on the total percentage of complex case managers, care coordinators, and service coordinators employed during the measurement period whose average monthly caseloads are less than 100 caseload points.

Administrative reporting based on the total percentage of complex case manager, care coordinators, and service coordinators (henceforth called "CCM/CC/SC") employed during the measurement period with average monthly caseloads points less than 100 points per CCM/CC/SC. Caseload points are determined based on the types of services being performed by the CCM/CC/SC:

i. Member enrolled in CCM = 1 point

ii. Member resides in NF and enrolled in SC = 0.5 points

iii. Member receives Home and Community Based Services (HCBS) = 1.5 points

iv. Member enrolled in CC = 0.4 points

v. Transitioned from long term nursing home facility to community = 2 points

Amount of Performance Withhold at Risk: 40%

If 95% of CCM/CC/SC's average caseload points are <=100, the Contractor is eligible to receive 30% of performance withhold at risk.

If 95% of CCM/CC/SC's average caseload points are <=90, the Contractor is eligible to receive 50% of performance withhold at risk.

If 95% of CCM/CC/SC's average caseload points are <=85, the Contractor is eligible to receive 75% of performance withhold at risk.

If 95% of CCM/CC/SC's average caseload points are <=80, the Contractor is eligible to receive 100% of performance withhold at risk.

Indiana PathWays for Aging Pay for Outcome Measure 2	
Pay for Outcome Measure	Service Coordination & Service Plan Timeliness
Pay for Outcome Sub Measure (if any)	A. Service Coordination Reassessment Timeliness B. Service Plans Update Timeliness
Brief Description	A. Percentage of Waiver members where the timeliness standards for completing the quarterly (HCBS), annual (NF), or triennial (select NF members) reassessments are met. B. Percentage of Waiver Members where the timeliness standard for a Service Plan Update after an assessment, reassessment, incident, and/or transition is met.
Percentage of Withhold at Risk	**Total 30%;** Sub Measure A 15%; Sub Measure B 15%

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ii. ***Measure: Service Coordination & Service Plan Timeliness.*** Administrative reporting, based on Contractor reported data, for Waiver members. Based on Contractor reported data, the percentage of Waiver members that met the timeliness standard for completion of required reassessments (HCBS – quarterly, NF enrolled on/after 7/1/2025 annual, or NF enrolled before 7/1/2025 triennial), and the percentage of members that met the timeliness standard for completion of service plan updates following an assessment, reassessment, incident, and/or transition. The measure will be evaluated based on two sub measures as follows.

a. ***Sub Measure A: Service Coordination Reassessment Timeliness.*** During the measurement year, this sub measure shall be defined as the percentage of members who received a quarterly reassessment within 100 days of the previous quarterly assessment (HCBS), an annual assessment within 365 days of the previous annual assessment (NF), or a triennial assessment within 1,095 days of the previous assessment (select NF members).

Amount of Performance Withhold at Risk: 15%

If Contractor's 2025/2026 service coordination reassessment timeliness rate is >= 70% Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service coordination reassessment timeliness rate is >= 75% Contractor is eligible to receive an incentive payment equal to sixty percent (60%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service coordination reassessment timeliness rate is >= 80% Contractor is eligible to receive an incentive payment equal to seventy percent (70%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service coordination reassessment timeliness rate is >= 85% Contractor is eligible to receive an incentive payment equal to eighty percent (80%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service coordination reassessment timeliness rate is >= 90% Contractor is eligible to receive an incentive payment equal to ninety percent (90%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service coordination reassessment timeliness rate is >= 95% Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

b. ***Sub Measure B: Service Plan Update Timeliness.*** During the measurement year, this sub measure shall be defined as the percentage of members that had their service plan updated within 30 days of an Assessment, Reassessment, Incident, and/or Transition.

Amount of Performance Withhold at Risk: 15%

If Contractor's 2025/2026 service plan update timeliness rate is >= 70% Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service plan update timeliness rate is >= 75%

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Contractor is eligible to receive an incentive payment equal to sixty percent (60%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service plan update timeliness rate is >= 80% Contractor is eligible to receive an incentive payment equal to seventy percent (70%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service plan update timeliness rate is >= 85% Contractor is eligible to receive an incentive payment equal to eighty percent (80%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service plan update timeliness rate is >= 90% Contractor is eligible to receive an incentive payment equal to ninety percent (90%) of the amount of the Performance Withhold at risk.

If Contractor's 2025/2026 service plan update timeliness rate is >= 95% Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.

Indiana PathWays for Aging Pay for Outcome Measure 3	
Pay for Outcome Measure	Participant Experience
Pay for Outcome Sub Measure (if any)	A. Getting Needed Care B. Getting Care Quickly C. Health Plan Customer Service
Brief Description	The percentage of members surveyed that expressed satisfaction with the care received and experience with health plan.
Percentage of Withhold at Risk	**Total 15%;** Sub Measure A 5%; Sub Measure B 5%; Sub Measure C 5%

iii. ***Measure: Participant Experience.*** Administrative reporting, based on State selected CAHPS Health Plan Adult Survey composite scores for measurement year (MY) 2025, reporting year (RY) 2026. The State selected CAHPS Health Plan Adult composite scores are outlined below.

Health Plan Adult Survey CAHPS Composite Categories

a. Sub Measure A: *Getting Needed Care*

b. Sub Measure B: *Getting Care Quickly*

c. Sub Measure C: *Health Plan Customer Service*

Amount of Performance Withhold at Risk: 15% (5% for each Sub Measure)

If Contractor's CY2025/RY2026 sub measure is at or above the Quality Compass MY2025 NCQA 90th percentile, the Contractor earns 100% for that sub measure.

If Contractor's CY2025/RY2026 sub measure is at or above the Quality Compass MY2025 NCQA 75th percentile, the Contractor earns 50% for that sub measure.

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EXHIBIT 2.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Indiana PathWays for Aging Pay for Outcome Measure 4	
Pay for Outcome Measure	Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)
Pay for Outcome Sub Measure (if any)	A. Reassessment After Inpatient Discharge B. Reassessment and Care Plan Update After Inpatient Discharge
Brief Description	The percentage of members discharged from inpatient facilities whose service/care plan was reassessed and updated within 30 days of discharge.
Percentage of Withhold at Risk	**Total 15%;** Sub Measure A 5%; Sub Measure B 10%

iv. ***Measure: Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC) (Based off HEDIS® MY2025 LTSS Specifications).*** The percentage of discharges from inpatient facilities for long-term services and supports (LTSS) organization members 60 years of age and older for whom a reassessment and service/care plan update occurred within 30 days of discharge. Measure is based on a sampling of eligible population. Reassessments must incorporate the 9 core elements as specified in technical specifications.

a. Sub Measure A: *Reassessment After Inpatient Discharge*. The percentage of discharges from inpatient facilities resulted in an LTSS reassessment within 30 days of discharge.

Amount of Performance Withhold at Risk: 5%

If Contractor's 2025/2026 reassessment rate is greater than or equal to 70% and less than 75%, the Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of Performance Withhold at risk.

If Contractor's 2025/2026 reassessment rate is greater than or equal to 75% and less than 80%, the Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of Performance Withhold at risk.

If Contractor's 2025/2026 reassessment rate is greater than or equal to 80%, the Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of Performance Withhold at risk.

b. Sub Measure B: *Care Plan Update After Inpatient Discharge as a Result of a Reassessment*. The percentage of discharges from inpatient facilities resulting in an LTSS reassessment and care plan update within 30 days of discharge.

Amount of Performance Withhold at Risk: 10%

If Contractor's 2025/2026 care plan update as a result of reassessment rate is greater than or equal to 70% and less than 75%, the Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of Performance Withhold at risk.

If Contractor's 2025/2026 care plan update as a result of reassessment rate is greater than or equal to 75% and less than 80%, the Contractor is eligible to

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receive an incentive payment equal to seventy-five percent (75%) of the amount of Performance Withhold at risk.

If Contractor's 2025/2026 care plan update as a result of reassessment rate is greater than or equal to 80%, the Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of Performance Withhold at risk.

4. Timing of Payments

FSSA will make its best efforts to distribute a report identifying Contractor's performance for the previous calendar year before the end of the current calendar year and the amount of incentive payments, if any, earned for such year for each outcome measure identified in Sections B.3. FSSA will make its best efforts to distribute payment to Contractor, subject to Section B.5 below, by December 31 of each year.

5. Conditions to Incentive Payments

FSSA will not have any obligation to distribute the Contractor's incentive payment to Contractor if FSSA has made a determination that Contractor is not eligible to participate in the pay for outcomes program, as described in Section B.1. The State encourages plans to share earned incentive payments with members and providers.

6. Non-Financial Incentives

In addition to the potential to earn incentive payments based on performance in the identified areas, FSSA may establish other means to incent performance improvement.

FSSA retains the right to publicly report Contractor performance. Information which may be provided in public reports includes but is not limited to Contractor's audited HEDIS report, Contractor's Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, and information based on Encounter Data Quality submissions or underlying encounter data submitted by Contractor. FSSA intends to distribute information on key performance indicators to participating managed care plan contractors and the public on a regular basis, identifying Contractor's performance, and comparing that performance to other managed care plan contractors, standards set by FSSA and/or external benchmarks or industry standards. FSSA may recognize managed care plan contractors that attain superior performance and/or improvement by publicizing their achievements. For example, FSSA may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. To the extent data is used in a public report, it must be received by the stated deadline in order to be published.

In year two (2) of the Contract, FSSA intends to include Contractor quality and performance indicators on materials distributed to potential members to facilitate MCE selection. The State reserves the right to develop a rating system advertising Contractor performance on areas such as consumer satisfaction, network access and quality improvement.

Following the initial year of the Contract, after which sufficient quality data is anticipated to be available, the State seeks to reward high performing MCEs through the auto-assignment logic. For example, in developing the auto-assignment methodology, the State reserves the right to consider factors such as Contractor performance on clinical quality outcomes as reported through HEDIS data, enrollee satisfaction as delineated through the CAHPS survey results, network access and other outcome measures.

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EXHIBIT 3.A

PROGRAM DESCRIPTION AND COVERED BENEFITS

1.0 Overview of the Program

Medicaid is a federal- and state-funded health care program providing reimbursement for reasonable and necessary medical care for persons meeting eligibility requirements. The Indiana Family and Social Services Administration (FSSA) administers the Indiana PathWays for Aging (PathWays) in Indiana. More detailed information about Indiana Health Coverage Programs (IHCP) is available on the State's website at in.gov/Medicaid/.

2.0 Eligible and Excluded Populations

The State has sole authority for determining whether individuals meet the eligibility criteria of the PathWays program. The FSSA Division of Family Resources (DFR) makes eligibility determinations.

Individuals aged 60 and above, in the following aid categories and do not fall into one of the excluded groups detailed below are enrolled with a Managed Care Entity (MCE) in the PathWays program:

- Aged individuals (MA A);
- Blind individuals (MA B);
- Disabled individuals (MA D);
- Individuals receiving Supplemental Security Income (SSI) (MASI); and
- M.E.D. Works enrollees (MADW, MADI).

This includes those who meet age requirements who are served on the Health and Wellness waiver or are in a nursing facility.

The following individuals are excluded from the PathWays program:

- Anyone 59 years of age and younger
- Partial Benefit Dually-Eligible individuals (QMB-only, SLMB-only, QI, QDWI)
- Anyone 59 years and younger on the Health and Wellness waiver, in a nursing home, or receiving hospice care
- 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

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- Emergency Services Only Members
- Family Planning Only Members
- HIP members with MAGI eligibility (or any non A, B, D)
- HHW members with MAGI eligibility (or any non A, B, D)

Individuals who are American Indians/Alaskan Natives, as verified by the DFR, in any of the PathWays program eligible categories may voluntarily enroll in the program through an opt-out process.

3.0 Delivery System

MCEs, which include both Indiana-licensed accident and sickness insurers and health maintenance organizations (HMOs), contract with FSSA to provide covered services to PathWays enrolled members. The MCEs manage care through a contracted network of providers.

The State requires MCEs to initiate network development. The State will evaluate the Contractor's progress in its network development efforts prior to the start date of the Contract. Contract Exhibit 1A, Scope of Work describes the network requirements in further detail. FSSA reserves the right to limit the enrollment, by county, of a particular MCE, in order to ensure members, have adequate choice of plans.

4.0 Covered Services

Individuals in this program will receive all traditional Medicaid services outlined in 405 IAC 5. Those who meet a specified Level of Care (LOC) will be eligible to receive HCBS Waiver services. Most services will be delivered via a capitated managed care arrangement and will be the responsibility of the managed care entity. However, a limited number of services are carved out of the capitated arrangement. These are Medicaid Rehabilitation Option (MRO), Adult Mental Health Habilitation Services Program (AMHH), Behavioral and Primary Care Coordination (BPHC), and certain high-cost drugs.

Many individuals will also have Medicare coverage. In these instances, Medicare is the first payer for all Medicare covered services. This applies to those services that are covered by both Medicare and Medicaid. For services not covered by Medicare, Medicaid will serve as the primary coverage.

Members enrolled in PathWays who meet LOC and receive waiver services are not eligible to receive CHOICE services.

Contract Exhibit 1A, Scope of Work describes the benefits and services in greater detail, including, but not limited to, the following:

- Medicaid services covered under the PathWays program.
- Self-referral services.
- Carved-out services including Medicaid Rehabilitation Option (MRO) services, 1915(i) State Plan home and community-based services. These services are reimbursed by Indiana Medicaid on a fee-for-service basis.
- Medicaid services excluded from the PathWays program include psychiatric treatment in a state hospital and ICF/IIDs. Individuals receiving these services will be disenrolled from the Contractor.

1. Non-covered services are those services identified in 405 IAC 5 as being non-covered, including the list of non-covered services set forth in 405 IAC 5-29-1.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

TABLE 2: INDIANA PATHWAYS FOR AGING BENEFITS

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Adult Mental Health and Habilitation (AMHH) – 1915(i) (405 IAC 5-21.6)	NO	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Services include: • Adult day services; • HCB habilitation; • Respite • Therapy and behavioral support services; • Addiction counseling; • Peer support services; • Supported community engagement services; • Care coordination; and • Medication training and support.
Behavioral and Primary Healthcare Coordination (BPHC) – 1915(i) (405 IAC 5-21.8)	NO	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Includes coordination of healthcare services to manage the healthcare needs of the recipient including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case and linkage to appropriate services. Limited to forty-eight (48) units per six (6) months.
Care Conferences	YES	Coverage of procedure code 99211 with the SC modifier for PathWays care conferences, payment of $40 reimbursement to the provider.

[2] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

[3] Services not reimbursed through the PathWays program are covered (available) and reimbursed for members under traditional Medicaid benefits reimbursement.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Chiropractors* (405 IAC 5-12)	YES (Self-referral)	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five (5) visits and fifty (50) therapeutic physical medicine treatments per member per year.
Dental Services (405 IAC 5-14)	YES	Coverage for medically necessary, covered dental services with no annual dollar limit applied. Reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs and emergency treatment. Full mouth series or panorex are limited to one (1) set per recipient every three (3) years, one (1) set per recipient every twelve (12) months for bitewing radiographs. Comprehensive detailed oral evaluation is limited to one (1) per lifetime, per recipient, per provider, with an annual limit of two (2) per recipient. A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient. Topical fluoride is not covered for recipients twenty-one (21) years of age or older. Prophylaxis is limited to one unit every twelve (12) months for non-institutionalized recipients over age (21). Periodontal surgery is a covered service only for cases of drug-induced periodontal hyperplasia. Payment for office visits is not covered; reimbursement is only available for covered services actually performed.
Diabetes Self-Management Training Services* (405 IAC 5-36)	YES	Limited to sixteen (16) units per member per year. Additional units may be prior authorized.
Emergency Services (IC 12-15-12-15 & 12-15-12-17)	YES (Self-referral)	Emergency services are covered subject to the prudent layperson standard of an Emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an Emergency medical condition are covered.
Eye Care, Eyeglasses and Vision Services (405 IAC 5-23)	YES (Self-referral)	Coverage for the initial vision care examination will be limited to one (1) examination every two (2) years for a recipient twenty-one (21) years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one (1) pair every five (5) years for members twenty-one (21) years and older.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Family Planning Services and Supplies **(405 IAC 10-2-1)**	YES (Self-referral)	Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines.
Federally Qualified Health Centers (FQHCs) (405 IAC 5-16-5)	YES	Coverage is available for medically necessary services provided by licensed health care practitioners.
Food Supplements, Nutritional Supplements, and Infant Formulas** (405 IAC 5-24-9)	YES	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.
Hospital Services Inpatient* (405 IAC 5-17)	YES	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Hospital Services Outpatient* (405 IAC 5-17)	YES	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Home Health Services** (405 IAC 5-16)	YES	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech language services; and renal dialysis for home-bound individuals.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Hospice Care** (405 IAC 5-34)	YES (including hospice in an institutional setting)	Hospice is available under Medicaid if the recipient is expected to die from illness within six (6) months. Coverage is available for two (2) consecutive periods of ninety (90) calendar days followed by an unlimited number of periods of sixty (60) calendar days.
Immunizations	YES (Self-referral)	Immunizations are self-referral to any IHCP-enrolled provider. Immunizations are covered regardless of where they are received.
Laboratory and Radiology Services (405 IAC 5-18. 405 IAC 5-27)	YES	Services must be ordered by a physician or other practitioner authorized to do so under state law.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Legend Drugs (405 IAC 5-24)	YES	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid. The following drugs are carved out of the PathWays program (full rating period): • Hepatitis C drugs (GPI 125350 or 123599) • Hemophilia Agents (GPI 8510) • Spinal Muscular Atrophy Treatments (GPI 7470) • Muscular Dystrophy Treatments (GPI 7460) • CAR-T Therapies (GPI 21651010 and 21651075) • Durable Genetic Therapy (GPI 8637) • Cystic Fibrosis Agents (GPI 453020 and 453099) • Sickle Cell Agents (GPI 828050 and 828070)
Long Term Acute Care Hospitalization	YES	Long term acute care services are covered. Prior authorization is required. An all-inclusive per diem rate is paid based on level of care.
Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)** (405 IAC 5-19)	YES	Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Mental health/Behavioral health services- **Inpatient**** **(State Psychiatric Hospital)** (405 IAC 5-20-1)	NO	PathWays members are disenrolled from the Contractor when admitted to a State psychiatric hospital.
Mental health/Behavioral health services- **Inpatient**** (405 IAC 5-20)	YES	Covered.
Mental health/ Behavioral health services- **Outpatient** (405 IAC 5-20-8)	YES, except MRO services	Coverage includes partial hospitalization services, Clinic Option services, mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Prior authorization is required for services that exceed twenty (20) units, per recipient, per provider, per rolling twelve (12) months.

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CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Medicaid Rehabilitation Option (MRO) -Community Mental Health Centers (405 IAC 5-21)	NO	Services provided by community mental health centers (CMHCs). Service packages are assigned based on level of need, as determined by an individualized assessment conducted by CMHCs, and qualifying behavioral health diagnosis. Additional units can be prior authorized when determined medically necessary. Services include: • Adult intensive rehabilitation services (AIRS) addition counseling; • Addiction counseling; • Behavioral health counseling and therapy; • Behavioral health level of need redetermination; • MRO case management; • CAIRS; • Medication training and support; • Psychiatric assessment and intervention; and • Skills training and development.
Non-legend Drugs (405 IAC 5-24)	YES	Medicaid covers non-legend (over-the-counter) drugs on its formulary. This is available via a link from the IHCP website at https://inm.providerportal.catamaranrx.com/providerportal/faces/PreLogin.jsp
Nurse-midwife services (405 IAC 5-22-3)	YES	Coverage is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse Practitioners (405 IAC 5-22-4)	YES	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Nursing Facility Services** **(Long-term)** (405 IAC 5-31-1)	YES	Requires pre-admission screening for level of care determination. PathWays coverage includes room and board; nursing care; medical and nonmedical supplies and equipment; durable medical equipment; medically necessary and reasonable therapy services; transportation to vocational/habilitation service programs.
Nursing Facility Services (Short-term) (405 IAC 5-31-1)	YES	Services for members in a nursing facility setting on a short-term basis, i.e., for fewer than thirty (30) calendar days.
Occupational Therapy** (405 IAC 5-22)	YES	Services must be ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct on-site supervision of a registered occupational therapist. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. Prior authorization is not required for initial evaluations, services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation. General strengthening exercise programs for recuperative purposes are not covered by Medicaid. Passive range of motion services as the only or primary modality of therapy and occupational therapy psychiatric services are not covered by Medicaid. Therapy for rehabilitative services will be covered for a recipient no longer than two (2) years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Organ Transplants (405 IAC 5-3-13)	YES	Coverage is in accordance with prevailing standards of medical care. The Contractor shall not pay for organ transplants unless the Contractor follows the written standards included in the State Plan that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to members. For additional information, please see the following: • https://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_3/3.1e.pdf • https://provider.indianamedicaid.com/ihcp/StatePlan/Section_3/3.1.f.g.h.pdf Prior authorization is required.
Orthodontics**	YES	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.
Out-of-state Medical Services** (405 IAC 5-5)	YES	Medicaid reimbursement is available for the following services provided outside Indiana: acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies; hospice services, subject to the conditions in 405 IAC 5-34-3; and diagnostic services, including genetic testing. All out-of-state services are subject to the same limitations as in state services. Prior authorization is required except for Emergency services (however, continuing inpatient treatment and hospitalization does require prior authorization). Services may be obtained in the following designated out-of-state cities subject to the prior authorization requirements for in-state services: Louisville, Kentucky; Cincinnati, Ohio; Harrison, Ohio; Hamilton, Ohio; Oxford, Ohio; Sturgis, Michigan; Watseka, Illinois; Danville, Illinois; and Owensboro, Kentucky. Recipients may obtain services in Chicago, Illinois if the recipient's physician determines the service is medically necessary, transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient's family, the service is not available in the immediate area, the recipient's physician complies with all of the criteria set forth in accordance with the state plan and 42 CFR 456.3. Prior authorization will not be approved for the following out of state services: nursing facilities, ICFs/IID, or home health agency services; or any other type of long-term care facility, including facilities directly associated with or part of an acute general hospital.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Physician Assistant (IC 25-27.5)	YES	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified Physician Assistant within the scope of the applicable license and certification.
Physicians' Surgical and Medical Services* (405 IAC 5-25)	YES	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of thirty (30) per calendar year per member per provider without prior authorization. New patient office visits are limited to one (1) per recipient, per provider within the last three (3) years.
Physical Therapy** (405 IAC 5-22)	YES	Services must be ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge, and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Podiatrists (405 IAC 5-26)	YES (Self-referral)	Reimbursement provided for podiatric services performed within the scope of the practice of the podiatric profession. Services covered shall include diagnosis of foot disorders and mechanical, medical, or surgical treatment of these disorders. Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than six (6) routine foot care visits per year are covered for patients with a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous; and has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet. Proof must be submitted of patient visit to a medical doctor or doctor of osteopathy for treatment or evaluation of the systemic disease during the six (6) month period prior to the rendering of routine foot care services. Prior Authorization is required for inpatient hospital stays and fitting or supplying of orthopedic shoes for patients with severe diabetic foot disease.
Rehabilitative Unit Services - Inpatient** (405 IAC 5-32)	YES	The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function or self-care activities.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Residential Substance Use Disorder (SUD) Services	YES	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: • ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services • ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services
Respiratory Therapy* (405 IAC 5-22)	YES	Services must be ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, Emergency, and oxygen equipment and supplies necessary for the delivery of oxygen, therapy within thirty (30) calendar days (up to thirty (30) units) following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Rural Health Clinics (405 IAC 5-16-5)	YES	Coverage is available for services provided by a physician, physician assistant, nurse practitioner, a clinical psychologist, or a clinical social worker. Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Home health services by a RHC to a homebound individual are only available in the case of those clinics that are located in an area that has a shortage of home health agencies as determined by Medicaid.

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CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Smoking Cessation and Tobacco Dependence Treatment **Services** (405 IAC 5-37)	YES	Treatment may include prescription of any combination of smoking cessation and tobacco dependence treatment products and counseling. Providers can prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment. Providers must order tobacco dependence treatment services for the IHCP to reimburse for the services. Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself. The IHCP does not require prior authorization for reimbursement for smoking cessation and tobacco dependence treatment products or counseling. The IHCP reimburses pharmacy providers for smoking cessation and tobacco dependence treatment products, including over-the counter products, only when a licensed practitioner prescribes them for a member, including utilization of the statewide standing order for tobacco cessation products. Only patients who agree to participate in tobacco dependence counseling may receive prescriptions for tobacco dependence treatment products. The prescribing practitioner may want to have the patient sign a commitment to establish a “quit date” and to participate in counseling as the first step in tobacco dependence treatment. A prescription for such products serves as documentation that the prescribing practitioner has obtained assurance from the patient that counseling will occur concurrently with the receipt of tobacco dependence drug treatment. Providers must perform tobacco dependence counseling for a minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) within the course of treatment. IHCP coverage of tobacco dependence counseling services is limited to a maximum of 10 units of counseling per member per calendar year.

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Speech, Hearing and Language Disorders* (405 IAC 5-22)	YES	Services must be ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Prior authorization is not required for initial evaluations, for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by physician prior to discharge or following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Transportation - Emergency* (405 IAC 5-30)	YES	Coverage has no limit or prior authorization requirement for Emergency ambulance or trips to/from hospital for inpatient admission/discharge, transportation for patients on renal dialysis or those residing in nursing homes, accompanying parent or recipient attendant (or both) or for a return trip from the emergency room in an ambulance, if use of ambulance is medically necessary for the transport.
Transportation – Non-emergency medical (405 IAC 5-30)	YES	Non-emergency medical travel is available when another alternative is not available.
Urgent Care Services	YES (Self-referral)	Urgent Care Services are covered provided that they are medically necessary. Urgent Care is needed for non-life threatening emergencies that cannot wait for a normal scheduled office visit.
HCBS Services For those with HCBS LOC determination		

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EXHIBIT 3.A

CONTRACT COMPLIANCE AND PAY FOR OUTCOMES

Service[2]	Reimbursed by MCE[3]	Limitations/Coverage
Included HCBS 1915(c) LTSS Waiver Services	*YES, BUT ONLY FOR THOSE ELIGIBLE	Please reference the most current version of the Indiana Health Care Provider manual for the most up to date covered services and their respective service definitions for those eligible for HCBS LTSS in the 1915(c) Managed Care Medicaid Waiver. Current list below: Adult Day Service Attendant Care Caregiver Coaching Home and Community Assistance Respite Community Home Share Assisted Living Community Transition Home Delivered Meals Home Modification Assessment Home Modifications Integrated Health Care coordination Nutritional Supplements Participant Directed Attendant Care Personal Emergency Response System Pest Control Specialized Medical Equipment and Supplies Structured Family Caregiving Transportation Vehicle Modifications

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EXHIBIT 5.A

CONTRACT DEFINITIONS

Listed below are definitions and acronyms used in the managed care Contracts. The following terms, when used in a contract, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other sections of the Contract, the specific language in the Contract shall govern. In addition to these definitions, refer to Indiana Law: IC 12-7-2 Chapter 2 Definitions.

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program. [42 CFR 455.2]

Abuse, Neglect and Exploitation (ANE) – Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

Actuary - An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. An actuary develops and certifies the capitation rates. [42 CFR 438.2]

Adjudicated Claim - A claim that has been received and processed by the Contractor which resulted in a payment or denial of payment.

Administrative Cost - All costs to the Contractor related to the administration of this Contract that are non-medical in nature.

Adverse Benefit Determination - As defined in 42 C.F.R. 438.400(b).

Affiliate - Any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership, and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the Contractor.

Aged and Disabled Waiver - Allows Indiana to provide an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities to return to community settings such as their own homes, apartments, Assisted Living or Community Home Share.

Agency review - A post-hearing process conducted by the FSSA Office of Hearings and Appeals to determine whether the appeal process was properly conducted.

Agent - Any individual who has been delegated the authority to obligate or act on behalf of a provider. [42 CFR 455.101]

Aligned Enrollment - The enrollment in a dual eligible special needs plan of full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and the dual

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eligible special needs plan's (D-SNP's) MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. When State policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as exclusively aligned enrollment.

Americans with Disabilities Act (ADA) - Public Law 101-336. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services.

American Indian or Alaska Native (AI/AN) enrollee - Any AI/AN individual eligible for services from an Indian health care provider.

Appeal - A request for a review of an action. An appeal is a special kind of complaint a member may make if they disagree with a decision to deny a request for health care services or payment for services they've already received. A member may also make a complaint if they disagree with a decision to stop services that they are receiving. For example, a member may ask for an appeal if Medicare doesn't pay for an item or service they think they should be able to get. There is a specific process that a member's health plan must use when they ask for an appeal. [42 CFR 438.400]

APS - Indiana's Adult Protective Services.

Area Agencies on Aging – A public or private nonprofit agency designated by the state to address the needs and concerns of all older persons at regional and local levels.

Assessment - An analysis of a patient's needs to determine which services shall be provided to the patient.

Auto-assignment - Process that automatically assigns a managed care member to an MCE if the member does not select an MCE within the allotted time frame.

Behavioral Health Services – Mental health and/or substance abuse services collectively.

Benefit Appeal – As distinguished from an Eligibility Appeal, a "Benefit Appeal" concerns an enrollee's request to contest a Contractor's adverse benefit determination by receiving a State Fair Hearing (SFH).

Benefits - The package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to enrollees assigned to the Contractor pursuant to the Contract with Indiana.

Blood Deductible - The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible. A blood deductible amount applies to the first 3 pints of blood (or equivalent units; applies only to whole blood or packed red cells - not platelets, fibrinogen, plasma, etc. which are considered biologicals). However, blood processing is not subject to a deductible. Calculation of the deductible amount considers both Part A and Part B claims combined. The blood deductible does not count toward meeting the inpatient hospital deductible or any other applicable deductible and coinsurance amounts for which the patient is responsible.

Breach (with respect to Protected Health Information (PHI) - The acquisition, access, use, or disclosure of protected health information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the protected health information.

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EXHIBIT 5.A

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Business Day - Monday through Friday, except for State of Indiana holidays.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) - Patient experience surveys that ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others.

Capitation Rate - The amount established as a fixed monthly payment per person, for which the Contractor provides a full range of covered services, pursuant to the rate setting methodology described in Exhibit 6A of this Contract.

Care Coordinator - An individual meeting Indiana required residential, education, and/or experience requirements that is assigned to every member with the primary responsibility for coordination of the member's LTSS, physical and behavioral health services.

Caregiver Collaboration Committee – A distinct state-sponsored committee developed by the contracted MCEs that includes an FSSA representative, informal caregivers from all regions of the state and all contracted MCEs, as well as at least one Informal Caregiver Coach from each MCE. The group will inform and provide feedback to the Contractors and FSSA about the policies and operations of the PathWays program.

Caregiver Supports - Training, education, and resources that will equip the Informal Caregiver with the necessary knowledge and skills to promote safe and appropriate services and supports to the member and to continue living in the community.

Care Management - A level of direct-contact services tailored to the member that 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 a 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.

Carved-out Services - As defined by the State, include services that are carved out of managed care program coverage, meaning that they are the financial responsibility of the State to provide to managed care members via fee-for-service (FFS) Medicaid benefits. This definition also includes services that could potentially require a managed care member to be disenrolled from a managed care plan and instead be reenrolled into traditional Medicaid to obtain the FFS benefit.

CFR - Code of Federal Regulations. - The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

Choice Counseling - The provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among MCEs and PCPs. Choice counseling does not include making recommendations for or against enrollment into a specific MCE. [42 CFR 438.2]

Claim Dispute - A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Clean Claim - A claim received by the Contractor or adjudication that requires no further information, adjustment, or alteration by the provider of the services to be processed and paid.

Clinical Practice Guidelines – Systematically developed tools or standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical

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circumstances. Such guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

CMS – Centers for Medicare & Medicaid Services - The federal agency within the United States Department of Health and Human Services (HHS), which administers the Medicare (Title XVIII) and Medicaid (Title XIX) programs, and the State Children's Health Insurance Program (Title XXI).

Co-insurance - The portion of an allowed charge that a member would be required to pay for a covered medical service after the deductible has been met if the member did not have Medicaid coverage. The co-insurance or a percentage amount is paid by Medicaid if the member is eligible for Medicaid.

Community Health Worker (CHW) - A person who meets the certification or experience qualifications required by the State to provide coordination of care and patient education services and care coordination in clinic and community settings for the purpose of disease prevention, promoting health, and increasing access to health care for individuals and their communities.

Complex Case Management - A level of service available to high-need/high-risk members who are determined Nursing Facility Level of Care (NFLOC) and are receiving LTSS in a home or community-based setting; or members with three (3) or more disease states which require the ongoing involvement of sub-specialists to manage and deliver disease-appropriate care; or members with 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 members who have had an inpatient hospital stay in the last ninety (90) days; or members with high dollar claims of over fifty thousand dollars (>$50,000) in six (6) months. Complex Case Management Services include all of the services and benefits from Care Management as well as additional benefits.

Consumer-Directed Worker - An individual who has been hired by a member participating in consumer direction or his/her representative to provide one or more eligible home and community-based services to the member. Does not include an employee of an agency that is being paid by a Contractor to provide services to the member.

Contractor - A managed care entity (MCE) organization or entity that has a prepaid capitated contract with the State of Indiana to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements and State and Federal law, rule, regulations, and policies.

Convicted - A judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Copayment or Copay - Per IC 27-13-1-8, copayment means an amount, or a percentage of the charge, that an enrollee must pay to receive a specific service that is not fully prepaid.

Corrective Action Plan (CAP) - A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Assessment and Performance Improvement activities and the outcomes of the activities, or to resolve a deficiency.

Cost Avoidance - The process of identifying and utilizing all confirmed sources of first- or third-party benefits before payment is made by the Contractor.

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EXHIBIT 5.A

CONTRACT DEFINITIONS

Covered Services - Pursuant to this contract, services individuals in this program will receive include all traditional Medicaid services. A limited number of services are carved out of the capitated arrangement. Also see Benefits.

Credentialing - The process of obtaining, verifying, and evaluating information regarding applicable licensure, accreditation, certification, educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.

Crisis Service - A DMHA defined service that is available at short notice to help members resolve a mental health, substance use, and/or suicide-related emergency or to support members while it is happening. These services can range from 24/7 warm lines or crisis hotlines to mobile crisis response and stabilization teams and acute crisis stabilization centers.

Critical Incident - Critical incidents in the HCBS setting are defined in accordance with 455 IAC 2-8-2 Protecting Individuals (Unusual Occurrence; Reporting). Also known as incidents falling in the category of unusual occurrences.

Cultural Competency - The ability for the Contractor, healthcare professionals, and social support providers to demonstrate cultural competence toward members/patients with diverse values, beliefs, and feelings that allows for a process that includes consideration of the individual social, cultural, and psychological needs of patients for effective cross-cultural communication with their health care providers in order to reduce health disparities and to provide optimal care to patients regardless of their race, gender, ethnic background, native languages spoken, and religious or cultural beliefs.

Days - Calendar days unless otherwise specified.

Deductible - For health insurance, the amount a person must pay toward medical expenses before insurance plan begins paying.

Development Disability - A severe, chronic disability manifested during the developmental period of childhood that results in impaired intellectual functioning or deficiencies in essential skills.

Direct Service Worker - Indiana Family and Social Services Administration defines a "Direct Service Worker" (or "DSW") as anyone who is employed (including self-employed) to provide person-centered services and supports to older adults or people with disabilities residing in home and community-based settings.

Disenrollment - The discontinuance of a member's eligibility to receive covered services through an MCE.

Division of Aging - A division of the Family and Social Services Administration. Supports the development of alternatives to nursing home care by coordinating and funding home and community-based services coordinated through a network of Area Agencies on Aging.

Division of Disability and Rehabilitative Services (DDRS) - A division of the Family and Social Services Administration. Assists citizens of Indiana, regardless of the severity of the disability, in becoming employed and living in the least restrictive and most appropriate environment possible.

Division of Family Resources (DFR) - A division of the Family and Social Services Administration. The State agency that offers help with job training, public assistance,

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supplemental nutrition assistance, and other services. The DFR make Medicaid eligibility determinations based on federal and state policy.

Division of Mental Health and Addiction (DMHA) - A division of the Family and Social Services Administration. The DMHA assists people with mental illness or addiction who are uninsured or underinsured to receive treatment and re-integrate into their community. The Division operates six state hospitals and partners with Indiana's Community Mental Health Centers (CMHC) to provide treatment in communities across Indiana.

Division of Supplier Diversity - A division of the Indiana Department of Administration that acts on behalf of the State of Indiana to actively promote, monitor, and enforce the standards for certification of minority, women, and veteran business enterprises.

Drug Formulary - List of drugs that includes therapeutic classes for both generic and brand-name medications. Within the formulary, a drug or dosage form may be designated as “preferred” or “non-preferred.” Preferred drugs generally require minimal or no prior authorization; non-preferred drugs require prior authorization and may also require periodic regimen review or specific billing requirements.

Dual Eligible Member - A member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only) and a Non QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

Durable Medical Equipment (DME) - Equipment that is necessary for ongoing medical issues. Durable medical equipment includes purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicaid. [42 CFR 414.202]

Earned Income - Earned income may include wages, tips, salaries, or net earnings from self-employment. It may also include other compensation received from performing work activity. Earned Income is often used in determining a person's eligibility for Medicaid and other social services available through the State.

Electronic Visit Verification (EVV) - A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

Eligibility Determination - The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.

Eligible member - Person certified by the State as eligible for medical assistance.

Eligible providers - Person, organization, or institution approved by the State as eligible for participation in Medicaid.

Emergency Medical Condition - Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in

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serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part. [42 CFR 438.114]

Emergency Medical Transportation - Per 836 IAC 1-1-1, emergency medical transportation means the transportation of emergency patients by ambulance and the administration of basic life support to emergency patients before or during such transportation.

Emergency Room Care - Includes care given for a medical emergency when a member believes that their health is in serious danger and every second counts. [42 CFR 405.440]

Emergency Services - Per 405 IAC 5-2-9, emergency services are defined as a service provided to a member after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Encounter - A record of a health care-related service rendered by a provider or providers to a member who is enrolled with a Contractor on the date of service.

Enrollee - A Medicaid recipient who is currently enrolled with a Contractor. [42 CFR 438.2]

Enrollee encounter data - The information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between the State and a Contractor that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818. [42 CFR 438.2]

Enrollment - The process by which an enrollee becomes a member of the Contractor.

Enrollment broker - An individual or entity that performs choice counseling or enrollment activities, or both. [42 CFR 438.810(a)]

Evidence-Based Practice – An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of health care professionals; and the unique needs, concerns and preferences of the individual receiving services.

Excluded Services - Defined by the State as services that are not covered under Indiana Medicaid. See 405 IAC 5-29-1.

Exclusive Alignment: When a State policy limits a D-SNP's membership to individuals with aligned enrollment (see 42 CFR 422.2)

External Quality Review - As used in CFR part 438 subpart E, the analysis and evaluation by an external quality review organization (EQRO), of aggregated information on quality, timeliness, and access to the health care services that a Contractor (described in 42 CFR 438.310(c)(2)), or their contractors furnish to Medicaid beneficiaries. [42 CFR 438.320]

External Quality Review Organization (EQRO) - As used in CFR part 438 subpart E, an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other external quality review-related activities as set forth in 42 CFR 438.358.

Family and Social Services Administration (FSSA) - Indiana Family and Social Services Administration is a health care and social service funding agency with eight care divisions established by Indiana to consolidate and better integrate the delivery of human services by state

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government. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy and Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.

Family or Family Member - A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may encompass family of choice for adult members which includes informal supports.

Federal Financial Participation (FFP) - Refers to the contribution that the Federal government makes to the Title XIX and Title XXI program. [42 CFR 400.203].

Federal Poverty Level (FPL) - Individual and family income guidelines set by the federal government for the administration of social service benefits. The state-specific guidelines are adjusted for the cost of living in each state. Financial eligibility for social service programs is often based on a percentage of the FPL.

Fee-for-Service (FFS) – A method of making payment for health services based on a fee schedule that payment for defined services. Also, Indiana Medicaid program for members not enrolled with a Contractor.

Fiscal Agent - A Contractor that processes or pays vendor claims on behalf of the Medicaid agency. [42 CFR 455.101]

FQHC - Federally Qualified Health Center

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 CFR 455.2]

Freedom of Choice - A state must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.

Grievance – A complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. A grievance is a complaint about the way a member's health plan is giving care. For example, a member may file a grievance if the member has a problem calling the plan or if the member is unhappy with the way a staff person at the plan has behaved toward them. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (refer to appeal). [42 C.F.R. 438.400(b)].

Grievance and Appeal System - The processes the Contractor implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them. [42 CFR 438.400(b)]

Habilitation Services and Devices - Habilitative services and devices include health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples may include therapy for a child who is not walking or talking at the expected age.

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These services may also include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings. [45 CFR 156.115(a)(5)]

Health Care Professional - A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist, licensed professional counselor, and licensed mental health counselor (LMHC).

Healthcare Effectiveness Data and Information Set (HEDIS) – Widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance.

Health Care Services - As used in CFR part 438 subpart E, all Medicaid services provided by an MCE, PIHP, or PAHP under contract with the state Medicaid agency in any setting, including but not limited to medical care, behavioral health care, and LTSS. [42 CFR 438.320]

Health Equity - Ensuring that everyone has the chance to be as healthy as possible considering factors outside of a person's control that can prevent them from achieving their best health.

Health Insurance - Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. [45 CFR 144.103]

Healthy Indiana Plan - Indiana Medicaid health-insurance program for Hoosiers ages 19 to 64 who meet specific income levels.

High-Risk Member - An Indiana Medicaid member who is enrolled with Health and Wellness Waiver services.

HIPAA - Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164.

HIPAA Rules - The rules adopted by and promulgated by the US Department of Health and Human Services ("HHS") under HIPAA and other relevant federal laws currently in force or subsequently made, such as the Health Information Technology for Economic and Clinical Heath Act ("HITECH"), as enumerated under 45 CFR Parts 160, 162, and 164, including without limitation any and all additional or modified regulations thereof.

HITECH - Health Information Technology for Economic and Clinical Health Act, Pub.L.111-5, Div. A, Title XIII, 13001(a), Feb. 17, 2009, 123 Stat. 226.

Home and Community-Based Services (HCBS) – Services that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility.

Home Health Care – Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social

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services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services. [42 CFR 440.70]

Home Health Services - Nursing services, home health aide services, therapy services, medical supplies, equipment, and appliances when provided to a member at his place of residence and on his or her physician's orders, or beginning March 1, 2020, ordered by the member's nurse practitioner, physician assistant, or clinical nurse specialist, as a part of the plan of care and is reviewed by the practitioner annually as part of a written plan of care. [42 CFR 440.70]

Home Medical Equipment (HME) - Indiana Code IC 25-26-21-2 defines home medical equipment 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.

Hoosier Care Connect – Indiana's health care program for individuals who are aged 65 years and older, blind, or disabled and who are also not eligible for Medicare or living in an institution. Enrollees also include individuals in Indiana's foster care program.

Hoosier Healthwise - Indiana's health care program for children, low-income families, and pregnant women. Different benefit packages are available to the various populations eligible for Hoosier Healthwise: Package A (Standard) and Package C (CHIP).

HoosierRx - A qualified State Pharmaceutical Assistance Program. For more information, go to: https://www.in.gov/medicaid/members/194.htm.

Hospice Care – A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Hospital Insurance. [42 CFR 418.3]

Hospitalization - Hospitalization means admission for treatment to a hospital, clinic, or other health care facility. Treatment as an out-patient is not considered to be hospitalization [40 CFR 159.153].

Incurred But Not Reported (IBNR) - The liability for services rendered for which claims have not been received by the Contractor.

Indian or American Indian - Any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian. [42 CFR 136.12].

Indiana Housing & Community Development Authority – Indiana statewide housing agency that provides housing opportunities, promotes self-sufficiency, and strengthens communities.

Indiana State Department of Health (IDOH) - The State agency responsible for promotion of health and for providing guidance on public health issues. For more information go to https://www.in.gov/health/.

Indian Health Care Provider - A health care program operated by the IHS or by an I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). [42 CFR 438.14(a)]

Indian Health Service (IHS) - The federal agency charged with administering the health programs for federally recognized American Indians.

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EXHIBIT 5.A

CONTRACT DEFINITIONS

Indiana PathWays for Aging – Indiana's health care program for Medicaid enrollees who are 60 years of age and older and are eligible for Medicaid on the basis of age, blindness, or disability. Enrollees include members who have a full Medicare benefit, those in a nursing facility, and those who are receiving long-term care services and supports in a home or community-based setting.

Indiana PathWays for Aging Dual Care: A D-SNP PBP that provides exclusively aligned enrollment and integrated Medicare coverage for PathWays eligible Medicaid members under the same corporate entity as an Indiana PathWays for Aging MCE.

Individualized Care Plan - A plan of care, with contractually defined minimum components, developed for each member based on the results of the member's initial screening and health risk assessment(s) to ensure that the care of members is adequately coordinated and appropriately managed.

Informal Caregiver - Family members, partner, friends, or neighbors who provide care for a member and is routinely involved in providing unpaid support and assistance to the member.

Informal Caregiver Assessment - A systematic process of gathering information that describes a caregiving situation and identifies the particular problems, needs, resources, and strengths of the family caregiver. It approaches issues from the caregiver's perspective and culture, focuses on what assistance the caregiver may need and the outcomes the family member wants for support, and seeks to maintain the caregiver's own health and well-being.

Information Systems - The component of the Contractor's organization which supports the Information Systems, whether the systems themselves are internal to the organization with a full spectrum of systems staffing, or externally contracted with internal oversight and support.

In Lieu of Services - Services or settings used in place of services and settings covered under the state plan. In Lieu of Services must be medically appropriate and cost effective as determined by the State. [42 CFR 438.3(e)(2)(iii)]

In-Network Provider - Any provider that is directly or indirectly employed by or has a provider agreement with the Contractor or subcontractor to the Contractor pursuant to the Contract between the Contractor and the State of Indiana.

Inquiry - A concern, issue or question that is expressed orally or in writing by a member.

Institution For Mental Disease (IMD) - A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance abuse disorders), 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 and whether it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases. [42 CFR 435.1010]

Interdisciplinary Care Team (ICT) - A team of individuals that are responsible for the initial assessment and on-going re-assessment and evaluation of qualified members, that are skilled in nursing, social work and behavioral health, with knowledge of local community resources to implement protocol-driven care modules for members. At a minimum, a member's ICT must include the member, the member's Care Coordinator, the member's Service Coordinator (as applicable), any member-selected supports including informal caregivers, and additional expertise as needed based on the person's medical and needs.

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Intermediate Care Facility (ICF/IID) Services – An optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence.

Intervention - An action or ministration that is intended to produce an effect or that is intended to alter the course of a pathologic process.

InterRAI - The interRAI suite of assessment instruments are comprehensive, standardized, reliable, and validated tools to support assessment and care planning in older adults, mental health, and disability services. See http://www.interrai.org.

Law - Statutes, codes, rules, regulations, and/or court rulings.

Level-of-Care (LOC) - A level of care determination is the outcome of the measure of an individual's care needs. This includes a determination of nursing home or institutional placement level of care need of an individual.

Lien - A legal claim that a person holds on another's property as a security for an indebtedness or charge.

Line of Business - Refers to one of the Indiana Medicaid programs.

Limited English Proficiency (LEP) - Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may have LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. [42 CFR 438.10].

Long-Term Care (LTC) Ombudsman Program - A statewide program that advocates for residents of long-term care facilities, which includes nursing facilities and licensed assisted living facilities, to promote and protect the resident rights guaranteed to residents under federal and state law.

Long Term Care Program - A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

Long-Term Services and Supports (LTSS) - Services and supports provided to individuals of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting [42 CFR 438.2].

Managed Care - An arrangement whereby a single provider or organization oversees the overall care of a patient to ensure cost-efficient quality health care to its members.

Managed Care Entity (MCE) - Organization contracted with the state of Indiana for this contract that meets all applicable requirements of Medicaid managed care organizations under Sections 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438, and IC 12-15 as may be amended.

Managed Care Program - A managed care delivery system operated by a State as authorized under section 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act [42 CFR 438.2].

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Mandated or Required Services - Services a state is required to offer to categorically needy clients under a state Medicaid plan (medically needy clients may be offered a more restrictive service package). Mandated services include the following: hospital, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinics, certain nurse practitioners, federally qualified health centers, renal dialysis services, EPSDT (under age 21), and medical transportation.

Mandatory Report State - Indiana mandatory reporting law that establishes a legal, enforceable duty for those who have contact with vulnerable populations to report suspected neglect, battery, or exploitation of an endangered adult to an APS unit or law enforcement. All reports are secured and kept confidential.

Marketing - Any communication or activity from the Contractor to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that Contractor's Medicaid product, or either to not enroll in or to disenroll from another Contractor's Medicaid product.

Marketing Materials - Materials that (1) are produced in any medium, by or on behalf of a Contractor; and (2) can reasonably be interpreted as intended to market the Contractor to potential enrollees. [42 CFR 438.104(a)]

MCE Reporting Manual - Office of Medical Policy and Planning (OMPP) instructions and specifications for managed care entities (MCEs) to submit the reports that comprise the Contractor's Reporting.

Medicaid - A Federal/State program authorized by Title XIX of the Social Security Act, as amended.

Medicaid Buy-In - This is an optional Medicaid program that allows individuals with a disability who work to retain Medicaid coverage. Individuals may pay a premium on a sliding fee scale based on their income. In Indiana, this program is called M.E.D. Works.

Medicaid-Covered Service - A service provided or authorized by a Medicaid provider for a Medicaid enrollee for which payment is available under the Medicaid program. A list of covered services is referenced in IC 12-15-5-1.

Medicaid Managed Care Regulations - The Federal law mandating, in part, that states ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated pursuant to the Balanced Budget Act (BBA) of 1997.

Medicaid-Medicare eligible - Also called Dual Eligible - Member who is eligible for benefits under both Medicaid and Medicare; also called dually eligible. Members in this category are bought-in for Part B coverage of the Medicare Program by the Medicaid Program.

Medicaid Rehabilitation Option (MRO) - Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.

Medical Expenses - Amounts paid to providers for the provision of covered physical health, behavioral health, and/or long-term care or other covered services to members.

Medical Necessity - Services or supplies that are proper and needed for the diagnosis or treatment of the member's medical condition, are provided for the diagnosis, direct care, and treatment of the member's medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the member or the member's doctor.

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Medically necessary services include covered services that are required for the care or well-being of the patient and are provided in accordance with generally accepted standards of medical or professional practice to prevent disease, disability or other adverse conditions or their progression, or to prolong life. [42 CFR 438.210(a)(5)]

Medically Needy - Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan but are insufficient to meet their costs of health and medical services.

Medical Records - All communications related to a patient's physical, mental health or long-term care condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Records do not include materials that are prepared in connection with utilization review, peer review, or quality assurance activities.

Medicare -The federal medical assistance program for people over the age of 65, for persons eligible for Social Security disability payments, and for certain workers or their dependents who require kidney dialysis or transplantation as defined under 42 USC 1395 et seq act.

Medicare Advantage (MA) - The managed care program established for beneficiaries of Medicare Part A and enrolled under Part B, pursuant to the Medicare Modernization Act of 2003.

Medicare Advantage Plan (MA Plan) - Health benefits coverage offered under a policy or contract by an MA organization, that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the Service Area of the MA plan (or in individual segments of a Service Area. [42 CFR 422.2 and 422.304(b)(2)]

Medicare Advantage Special Needs Plan (MA SNP) - A Medicare Advantage Plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs Enrollees and provides Part D benefits under 42 CFR Part 423 to all Enrollees; and has been designated by CMS as meeting the requirements of a MA SNP as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population. [42 CFR 422.2 and 422.4(a)(1)(iv)]

Medicare Prescription Drug Program (Part D Drug Benefit) - The prescription drug benefit for Medicare beneficiaries. [42 CFR Part 423]

M.E.D. Works - An Indiana program to provide Medicaid coverage to working individuals with disabilities who otherwise would lose or be ineligible for Medicaid coverage. It has separate eligibility requirements and a recipient premium structure based on a sliding fee scale for those individuals with disabilities who work.

Member - An eligible individual who is enrolled in Indiana Medicaid. Also referred to as enrollee, Title XIX Member or Medicaid Member.

Member Months - The number of months an enrollee or a group of enrollees is covered by Medicaid over a specified time period, such as a year. [42 CFR 428.8(b)]

Mental Health Services - The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling, or supervision of persons who have a mental illness.

MLR - Medical Loss Ratio as defined in accordance with 42 CFR 438.8.

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MLTSS - Managed Long-Term Services and Supports refers to the delivery of long-term services and supports through capitated Medicaid managed care programs.

National Committee for Quality Assurance (NCQA) – An independent 501c nonprofit organization that works with policymakers, employers, doctors, patients and health plans to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

National Provider Identifier (NPI) - The ten (10) digit number issued by CMS which is the standard unique identifier for health care Providers in standard transactions.

Natural Supports - Those relationships the member has with friends, family, and their community at large that enhance the quality and security of a member's life**.**

Network - A list of the doctors, other health care providers, and hospitals that a Contractor contracts with directly, or employs through a subcontractor, to provide medical care to its members. These providers are called "network providers" or "in-network providers." A provider that isn't contracted with the Contractor is called an "out-of-network provider."

Network Provider - Any provider, group of providers, or entity that has a network provider agreement with the MCO or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render Covered Services as a result of this Contract. A network provider is not a subcontractor by virtue of the network provider agreement. [42 CFR 438.2]

Nursing Facility - A facility which primarily provides to residents skilled nursing care and relate services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.

NFLOC - Nursing Facility Level of Care determined through an assessment by a level of care vendor for determination.

Non-Participating Provider - A provider who does not accept assignment on all Medicaid claims.

Office of Medical Policy and Planning (OMPP) - The Office of Medical Policy and Planning is under the Indiana Family and Social Services Administration (FSSA).

Options Counseling - Options Counseling, is an Area Agency on Aging function, as defined by the Older Americans Act, and will be a service AAAs continue to provide (e.g., counseling pertaining to Title III services, Social Services Block Grant, OAA, etc.) in their role as Aged and Disabled Resource Centers. MCEs do not conduct Options Counseling.

Other Full-Benefit Dually Eligible (FBDE) - A federal category of Medicaid where the member is eligible for Medicaid either categorically or through optional coverage groups but is not enrolled for QMB or SLMB. An FBDE is eligible for Medicaid payment of Medicare premiums, deductibles, co-insurance and co-pays (except for Part D).

Out-of-Network Provider - Any provider that is not directly or indirectly employed by or does not have a provider agreement with the Contractor or any of its subcontractors pursuant to the Contract between the Contractor and the State of Indiana.

Outpatient Hospital Services - Outpatient hospital services mean preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

(1) are furnished to outpatients;

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(2) are furnished by or under the direction of a physician or dentist; and
(3) are furnished by an institution that:
    (i) is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
    (ii) meets the requirements for participation in Medicare as a hospital; and
(4) may be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State. [42 CFR 440.20]

Participating Provider - Per IC 27-13-1-24, a participating provider means a provider who, under an express or implied contract with: (1) the health maintenance organization; or (2) a contractor of the health maintenance organization or any subcontractor of a contractor of the health maintenance organization; has agreed to provide health care services to enrollees with an expectation of directly or indirectly receiving payment, other than copayment or deductible, from the health maintenance organization.

Party in Interest - As defined in 1318(b) of the Public Health Service Act.

PASRR - Preadmission Screening and Resident Review - a set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.

Pass-through Payments - As defined at 42 CFR 438.6.

Patient Liability - The amount of an enrollee's income, as determined by the State, to be collected each month to help pay for the enrollee's nursing facility stay.

Per diem - Daily rate charged by institutional providers.

Performance Improvement Project (PIP) - A plan to remediate an identified program deficiency in response to a sanction or action by the State involving a process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

Performance Standards - Standardized measures designed to assist in evaluating, comparing, and improving the performance of the Contractors.

Person-centered planning process - Person-centered planning is a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community. Most important, it is a process that is directed by the person who receives the support. [42 CFR 441.301(c)(1)]

Pharmacy Benefits Manager (PBM) - An entity responsible for the provision and administration of pharmacy services.

Physician Services - Include services provided by an individual licensed under State law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included. [42 CFR 414.2]

Plan - State Plan, or Plan, refers to the comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the Social Security Act, to administer or supervise the administration of a Medicaid program in accordance with Federal requirements. [42 CFR 400.203]

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Plan of care (POC) - A formal plan developed to address the specific needs of an individual. It links clients with needed services.

Population Health - The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Potential Enrollee - A Medicaid-eligible recipient who is not yet enrolled with a Contractor. [42 CFR 438.10(a)]

Pre-admission screening (PAS) - A nursing home and community-based services program implemented that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.

Preauthorization - Preauthorization (or prior authorization) means the process through which a request for provisional affirmation of coverage is submitted to CMS or its contractors for review before the service is provided to the beneficiary and before the claim is submitted for processing. Through this process the Contractor authorizes, in advance, the delivery of covered services based on factors, including but not limited to, medical necessity, cost effectiveness, in compliance with any applicable contract or policy provisions [42 CFR 419.81].

Premium - Premium means any enrollment fee, premium, or other similar charge [42 CFR 447.51].

Prescription Drug - Prescription drug means any drug (including any biological product, except for blood and blood components intended for transfusion or biological products that are also medical devices) required by Federal law (including Federal regulation) to be dispensed only by a prescription, including finished dosage forms and bulk drug substances subject to section 503(b) of the Social Security Act [21 CFR 2023.3(y)].

Prescription Drug Coverage - Prescription drug coverage means coverage of Part D drugs that is either standard prescription drug coverage or basic alternative coverage [42 CFR 423.100].

Prevalent - A non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient. [42 CFR 438.10(a)]

Prevention and Wellness Program - A multi-disciplinary, continuum-based approach to improve the health of enrollees that proactively identifies populations with, or at risk for, certain medical conditions that: (1) supports the physician/patient relationship and place of care, (2) emphasizes prevention of exacerbation and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management, and (3) continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health.

Primary Care - All health care services, and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes the service. [42 CFR 438.2].

Primary Care Doctor - See Primary Medical Provider.

Primary Care Provider (PCP) - See Primary Medical Provider.

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Primary Medical Provider (PMP) - Is a primary care physician or other licensed health practitioner practicing in accordance with State law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. At a minimum, providers allowed to serve as PMPs must include physicians, physician assistants, and advanced practice registered nurses. Also known as a Primary Care Provider (PCP) or primary care doctor.

Prior Authorization (PA) - See Preauthorization.

Privacy Rule - Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164.

Program of All-inclusive Care to Elderly (PACE) - A program of all-inclusive care for the elderly that is operated by an approved PACE organization and that provides comprehensive and coordinated healthcare services to enrollees in accordance with a program agreement.

Protected Health Information (PHI) - Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium (and collectively defined in IC 4-1-6-1 and IC 4-1-11-3, "PII") on the State's behalf pursuant to and consistent with the services performed by the Contractor under the Contract with Indiana.

Provider - A provider is defined as any individual, organization, or institution (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, ambulatory surgical centers, outpatient clinics, or other entity that is licensed or otherwise authorized to provide any of the covered services in the State in which they are furnished) that provides medical services to beneficiaries covered under this Contract. Provider does not include consumer-directed workers (refer to Consumer-Directed Worker); nor does provider include the FEA (refer to Fiscal Employer Agent) [42 CFR 438.2].

Provider Agreement - An agreement between the Contractor and a provider or between the Contractor's subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to the Contractor's members.

Prudent Layperson - For purposes of determining whether an emergency medical condition exists, an individual without medical training who relies on the experience, knowledge, and judgment of a reasonable individual to make a decision regarding whether or not the absence of immediate medical attention will result in 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of a bodily part or organ.

Qualified Disabled Working Individual (QDWI) - A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.

Qualified Medicare Beneficiary (QMB) - The program is for people who receive Part A Medicare and whose income is below 100 percent of poverty. This program pays Medicare co-payments and co-insurance amounts for medical services covered by Medicare, including the co-payments for Medicare-approved skilled nursing home care. It also pays the Medicare Part B premiums for eligible clients.

Qualified Medicare Beneficiary Dual Eligible Member (QMB DUAL) - A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI

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asset limit. Medicaid benefits for QMB members include payment of Medicare premiums, coinsurance, and deductibles only.

Qualified Medicare Beneficiary (QMB) Only - A federal category of Medicaid eligibility where the member's benefits are limited to payment of the member's Medicare Part A (if member is not entitled to free Part A) and Part B premiums as well as deductibles and co-insurance or copayment for Medicare-covered services only.

Qualified Medicare Beneficiary Plus (QMB+) - A federal category of Medicaid eligibility where the member's benefits include payment of the member's Medicare premiums, deductibles, and co-insurance or copayment on Medicare-covered services in addition to Traditional Medicaid benefits.

Qualifying Individual (QI) - A federal category of Medicaid eligibility where the member's benefit includes payment of the member's Medicare Part B premium. The Eligibility Verification System (EVS) identifies this coverage as Qualified Individual.

Quality Improvement Project - A planned strategy for program improvement and is incorporated into the Contractor's Quality Assessment and Performance Improvement Report.

Quality Management - The evaluation and assessment of member care and services to ensure adherence to standards of care and appropriateness of services; can be assessed at a member, provider, or population level.

Recipient Identification Number (RID) - The unique number assigned to a member who is eligible for Medicaid services. May also be Member Identification Number.

Recoupment - The process by which a Contractor, the State of Indiana, or the Federal government, or any of their Bureaus, Agencies or Contractors recover Title XIX monies paid to an MCO, provider or enrollee.

Referral - A verbal, written, telephonic, electronic, or in-person request for health services.

Rehabilitative Services and Devices - Include health care services and devices to help a member recover from an illness or injury. These services may be given by nurses and physical, occupational, and speech therapists. Examples may include working with a physical therapist to help a member walk and with an occupational therapist to help a member get dressed.

Reinsurance - A stop-loss program to be purchased by the Contractor from a commercial reinsurer for the partial reimbursement of covered medical services to transfer risk from the Contractor to the reinsurer.

Related Party - A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the Contractor and their immediate families, subcontractors, wholly owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

Religious Grounds - Moral guidance on various aspects of health care delivery based on a religious organization's theological and moral teachings.

Reportable Unusual Occurrence – An incident of suspected abuse, neglect, or exploitation or other situations that place at risk an adult or child receiving HCBS.

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Request For Proposal (RFP) - A document which describes the scope of services required and which instructs a prospective offeror how to prepare a response (a proposal).

Rural Health Clinic (RHC) – An outpatient facility that is primarily engaged in furnishing physician and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.

Risk Contract - Contract between the State and MCE Contractor, under which the Contractor: 1. Assumes risk for the cost of the services covered under the Contract, and 2. Incurs loss if the cost of furnishing the services exceeds the payments under the Contract. [42 CFR 438.2]

Risk Corridor - A risk sharing mechanism in which states and the Contractor may share in profits and losses under the contract outside of a predetermined threshold amount. [42 CFR 438.6]

Room and Board - The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when an individual lives in an institutional setting (e.g., NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an Alternative HCBS Setting or an apartment like setting that may provide meals.

Service Authorization - A managed care enrollee's request for the provision of a service. [42 CFR431.201]

Service Coordination - A process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic LTSS and related environmental and social needs of each individual to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence.

Service Coordinator – Individuals meeting Indiana residential, educational and/or experience requirements responsible for the development and continuous modification of the Service Plan for members who are determined NFLOC and receiving LTSS, 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 caregiver.

Service Gap – A delay in initiating any long-term care service and/or a disruption of a scheduled, ongoing HCBS that was not initiated by a member, including late and missed visits.

Service Plan – LTSS-specific, person-centered support plan, developed utilizing the person-centered minimum service planning process for assisting members in gaining access to long term care services, as well as medical, social, housing, educational, and other services regardless of the funding source for the services to which access is gained to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

Shall – Indicates a mandatory requirement or a condition to be met. Note: The term 'Shall' is used interchangeably in this Contract with the term 'Must'.

Significant Change in Medical Condition – a deterioration in health, mental, or psychosocial status in either life-threatening circumstances or clinical complications.

Skilled Nursing Care - A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse). [42 CFR 409.44.]

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Special Health Care Needs (SHCN) - Serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

Specialist - A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems. A specialist is a board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

Specialized Medical Supplies - The specialized medical equipment and supplies service includes medically prescribed items required by the participant's service plan, which assist the participant in maintaining their health, welfare and safety, and enable the participant to function with greater independence in the home.

Specialty Services - Includes any required Essential Hospital Services, Centers of Excellence, and specialty physician services.

Specified Low-Income Medicare Beneficiary (SLMB) Only - The member's benefits are limited to payment of the member's Medicare Part B premium only.

Specified Low-Income Medicare Beneficiary Plus (SLMB+) - The member's benefits include payment of the member's Medicare Part B premium in addition to Traditional Medicaid benefits throughout each month of eligibility, including deductibles, co-insurance and co-pays (except for Part D).

SSA - Social Security Administration.

SSI - Supplemental Security Income.

State – The State of Indiana, including, but not limited to, any entity or agency of the state.

State Fair Hearing (SFH) Process - The State process set forth in subpart E of part 431-chapter IV, title 42 which allows members the opportunity to appeal the Contractor's decisions to the State. Refer to 405 IAC 1.1 for the appeal procedures for applicants and recipients of Medicaid [42 CFR 438.400(b)].

State Fiscal Year - The Indiana budget year-State fiscal year: July 1 through June 30.

Subcontract - An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor, specifically related to securing or fulfilling the Contractor's obligations under the terms of the Contract with Indiana when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by the Contract between Indiana and the Contractor.

Subcontractor - Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations under the terms of the contract between Indiana and the Contractor.

Subsidiary - An entity owned or controlled by the Contractor.

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Substance Use Disorder (SUD) Services - The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral, or supervision of individuals who are using or have abused substances.

Supplemental Security Income (SSI) and SSI Related Groups - Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or have a disability and have household income levels at or below 100 percent of the FPL.

Temporary Assistance for Needy Families (TANF) - Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act.

Third Party Liability (TPL) - A member's medical payment resources, other than Medicaid, available for paying all or part of the cost of services for the enrollee.

Transition Allowance - A per member allotment not to exceed one thousand five hundred dollars ($1,500) per lifetime which may, at the sole discretion of the Contractor, be provided to a member as a cost-effective alternative to continued institutional care for which the Contractor is responsible for to facilitate transition to the community.

Treatment - A procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue.

Unearned Income - Disability payments or other funds that an individual receives without any physical or mental work performed. Examples of unearned income may be Social Security Disability Insurance Benefits, income from a trust, investments, support payments, or funds received from any other source other than work.

Urgent Care - Urgent care services mean services furnished to an individual who requires services to be furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition. [42 CFR 405.400]

USC - United States Code.

Unusual Occurrence - Is defined in 455 IAC 2-4-27. It means an incident of suspected abuse, neglect, exploitation, or other situations that place at risk an adult or child receiving HCBS.

Waiver Services LOC - Level of Care determined through an assessment submitted by the Contractor to an LOC vendor for determination of eligibility for HCBS waiver services.

Waste - is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Wellness - An approach to health care that emphasizes not merely the absence of disease or infirmity but the pursuit of optimum health. It is an active process of helping members become aware of and make choices that will help them to achieve a healthy and more fulfilling life. Wellness includes preventing illness, prolonging life, and improving quality of life, as opposed to focusing solely on treating diseases.

Withhold Arrangement - Payment mechanism under which a portion of a capitation rate is withheld from a Contractor and a portion of or all the withheld amount will be paid to the Contractor for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. [42 CFR 438.6]

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EXHIBIT 6.A

INDIANA PATHWAYS FOR AGING CAPITATION RATES

Actuarial Certification:

The actuarial certification for each Contract year is incorporated in this Contract by reference. Actuarial certifications or amendments to certifications that have been signed by contracted entities and approved by CMS will be considered binding on all parties. As a matter of convenience, rates and other information from the certification are reproduced in this section of the Contract, but the certifications generally contain additional detail that should also be considered a part of this Contract.

Note on Capitation Rates:

The capitation rates listed in this exhibit shall apply for the rating periods July 1, 2024 through June 30, 2026 (State Fiscal Years 2025 and 2026).

Note on Rate Adjustment:

To the extent covered benefits or State-directed fee schedules are adjusted, capitation rates will be subject to revision in order to reflect the required program change. Future capitation rates will also be adjusted each year to reflect new base year data.

From time to time the State may adjust other fee schedules related to covered services for which reimbursement is not State-directed, as defined in 42 CFR 438.6(c)(iii), under this Contract. Where reimbursement is not State-directed, the Contractor may negotiate separate and distinct reimbursement with service providers, constrained only by other Contract provisions, such as access requirements. Should the State change these other fee schedules, there will be no related capitation rate adjustment.

Note on LTSS Rates: Institutional/Community Mix:

Each Contractor will be paid a blended capitation rate for members enrolled in the long term supports and services (LTSS) rate cells. This blended capitation rate will be based on the Contractor-specific target HCBS enrollment percentage assumed in each year's capitation rate development process. For example, if a Contractor's target HCBS enrollment percentage for a particular rating year is 70%, the contractor will be paid LTSS capitation rates during that rating year that are set equal to a blend of 70% of the developed HCBS capitation rate component and 30% of the developed nursing facility capitation rate component. For each year, the actuarial certification report will outline the methodology for developing each Contractor's target HCBS enrollment percentage, which will be based on the Contractor's HCBS enrollment percentage in a recent month prior to the rating year, plus an additional increase in HCBS enrollment percentage that is expected to be achieved during the rating year.

For State Fiscal Year 2025 – the first year of the program – it is anticipated that each Contractor's target HCBS enrollment percentage will be determined retroactively after the rating year starts, once initial program enrollment for each Contractor is known.

For State Fiscal Year 2026, each Contractor's target HCBS enrollment percentage will be updated in a future amendment to reflect each Contractor's June 2025 program enrollment.

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EXHIBIT 6.A

INDIANA PATHWAYS FOR AGING CAPITATION RATES

Note on Incentive Payment Withholding:

The capitation rates listed in this exhibit do not reflect any withhold amounts.

For State Fiscal Year 2025 the State will withhold one point eight five percent (1.85%) of the approved capitation payments from Contractor.

For State Fiscal Year 2026 the State will withhold one point eight five percent (1.85%) of the approved capitation payments from Contractor for the July through December 2025 time period, and two percent (2.00%) of the approved capitation payments from Contractor for the January through June 2026 time period.

The percentage withholding will increase in future Contract years, as listed in Exhibit 2A, the Contract Compliance and Pay for Outcomes Contract Exhibit. Withhold payments will be calculated as set forth in Section B of Exhibit 2A, and the Contractor may be eligible to receive some or all of the withheld funds based on Contractor's performance in the areas outlined therein.

Note on Risk Corridor:

For State Fiscal Years 2025 and 2026 the State is implementing a two-sided risk corridor around the benefit cost portion of per member per month capitation rates. This risk corridor calculation shall be calculated separately for each Contractor, by program and year. The Contractor shall retain at most two percent (2%) of the overall gains or losses. The Contractor is at full risk for the first one point five percent (1.5%) of gains or losses. For gains and losses over one point five percent (1.5%) and up to two point five percent (2.5%) the State and Contractor shall share the risk evenly. Gains or losses above the first two point five percent (2.5%) revert to the State.

The targeted benefit cost shall be calculated by the State for each Contractor by program and year. The targeted benefit cost shall be calculated according to the method described in the actuarial certification for each applicable Contract year incorporated in this Contract by reference.

The actual benefit cost incurred by the Contractor shall include all regular medical expenditures in the encounter data. For sub-contracted services, only the amount paid to providers may be included; sub-contracted administrative costs are excluded. Expenditures will be evaluated net of selected costs, including third-party liability, pharmacy supplemental rebates, net reinsurance recoveries, and nursing facility supplemental payments. Benefit costs considered for the risk corridor calculation will not include non-encounterable data or any MCE overpayments present in the encounter data.

A reconciliation, to be calculated and finalized at the sole discretion of the State, will compare the actual per member per month benefit cost incurred by the Contractor to the targeted benefit cost, and result in a per member per month amount. The dollar value of the remittance is the product of the per member per month amount and the Contractor's calendar year member months.

A full reconciliation of State Fiscal Year 2025 dates of service will occur using claim experience with runout through March 31, 2026. A full reconciliation of State Fiscal Year 2026 dates of service will occur using claim experience with runout through March 31, 2027.

Note on State Fiscal Year 2025 Capitation Rates

The following rate adjustments are anticipated at a future time, but are not reflected in the capitation rates documented in this section:

- Adjustment to reflect updates made to the State-directed outpatient hospital fee schedule for State Fiscal Year 2025

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- Adjustment to reflect any State-directed Hospital Assessment Fee (HAF) fee schedule changes that become effective during State Fiscal Year 2025
- Adjustment to reflect any State-directed nursing facility, HCBS and home health fee schedule changes that become effective during State Fiscal Year 2025
- Adjustment to reflect any State-directed PFAC fee schedule changes that become effective during State Fiscal Year 2025
- Adjustment to reflect any State-directed physician and ancillary fee schedule changes that become effective during State Fiscal Year 2025
- Adjustment to reflect any other changes made to State-directed fee schedules during State Fiscal Year 2025
- Adjustment to update LTSS capitation rates based on each Contractor's target HCBS enrollment percentage mix for State Fiscal Year 2025
- Adjustment to reflect final payments associated with the nursing facility supplemental payment, based on actual utilization during the rating year

The table below displays rates with and without funding for the nursing facility supplemental payments, which will be paid to the MCEs as a separate payment term distinct from the main portion of the capitation rates. The State will provide instruction to the MCEs for how these funds are to be distributed to providers, including the amount to be paid to each provider.

Rates Effective July 1, 2024 through June 30, 2025, Before Adjustment for 1.85% Withhold and After Application of Blended LTSS Rate Methodology

Rate Cell	Rate w/o NF Supplemental Add-On	Rate w/ NF Supplemental Add-On
Dual LTSS Adult	$5,635.80	$6,972.99
Non-Dual LTSS Adult	$9,389.01	$10,433.52
Dual Adult	$306.44	$306.44
Non-Dual Adult	$1,807.24	$1,807.24

Note on State Fiscal Year 2026 Capitation Rates

The following rate adjustments are anticipated at a future time, but are not reflected in the capitation rates documented in this section:

- Adjustment to reflect updates made to the State-directed outpatient hospital fee schedule for State Fiscal Year 2026
- Adjustment to reflect any State-directed Hospital Assessment Fee (HAF) fee schedule changes that become effective during State Fiscal Year 2026
- Adjustment to reflect any State-directed nursing facility, HCBS and home health fee schedule changes that become effective during State Fiscal Year 2026
- Adjustment to reflect any State-directed PFAC fee schedule changes that become effective during State Fiscal Year 2026

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- Adjustment to reflect any State-directed physician and ancillary fee schedule changes that become effective during State Fiscal Year 2026

- Adjustment to reflect any other changes made to State-directed fee schedules during State Fiscal Year 2026

- Adjustment to update LTSS capitation rates based on each Contractor's target HCBS enrollment percentage mix for State Fiscal Year 2026, based on actual program enrollment from June 2025

The table below displays rates with and without funding for the nursing facility supplemental payments, which will be paid to the MCEs as a separate payment term distinct from the main portion of the capitation rates. The State will provide instruction to the MCEs for how these funds are to be distributed to providers, including the amount to be paid to each provider.

Rates Effective July 1, 2025 through June 30, 2026, Before Adjustment for 1.85%/2.00% Withhold and After Application of Blended LTSS Rate Methodology

Rate Cell	Rate w/o NF Supplemental Add-On	Rate w/ NF Supplemental Add-On
Dual LTSS Adult	$5,762.46	$7,243.34
Non-Dual LTSS Adult	$10,464.23	$11,612.83
Dual Adult	$244.09	$244.09
Non-Dual Adult	$1,817.85	$1,817.85