Managed Long-Term Services and Supports Scope of Work Draft Excerpts

The following managed long-term services and supports (MLTSS) scope of work (SoW) excerpts are near-final drafts. These excerpts have been assembled for the benefit of stakeholders who have supported the design of this program from the outset. Developing a SoW for a new program that will be subject to competitive procurement necessarily requires materials be kept confidential and free from the influence of potential bidders, but at the same time the State wishes to show clear examples of how the stakeholder design inputs have translated into actual contract language. Broadly, this material reflects requirements that will be placed on Managed Care Entities (MCEs) that will serve Hoosiers under this program in the future. The material was drafted based on extensive discussions with stakeholders and with a constant eye toward ensuring Hoosiers served under the program will be better able to receive quality, person-centered, coordinated care that helps them age in the place of their choosing. Excerpts are not necessarily reflective of the full language within each numbered contract section but are examples highlighting requirements relevant to this stakeholder engagement and previously expressed topics of interest. Note that the future program name (e.g., Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, in the case of our three existing managed care programs) has not been determined at this time and is reflected in these excerpts as "[MLTSS Program Name]".

Administrative Requirements Excerpts Related to March 30th, 2022 Information Sharing Presentation

2.1 Eligibility Requirements

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

- *Age and Target Group*

  In order to be eligible to enroll in a 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 are 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 age 60 years of age or over who are enrolled in Medicaid based on eligibility as: Aged (MA A) Blind (MA B) Disabled (MA D) SSI recipients (MASI) MED Works (MADW, MADI) Full-Benefit Dually-Eligible individuals (QMB-also, SLMB-also, and FBDE)

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

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

- *MCE Assignment*
  For individuals who come into the program with no current Medicaid coverage, MCE assignment will be effective on the date of eligibility approval. Medicaid coverage may be effective up to three (3) months retroactively from their application date. Retroactive coverage will be in the fee for service (FFS) program, the managed care assignment will not be retroactive.

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

eligibility.

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

Individuals will have the chance to change a health plan:

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

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

2.1.1 Eligibility Determination Process

[Please note that additional information about enrollment processes will be shared in subsequent excerpts from other sections of the Scope of Work]

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.

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.

2.3 National Committee for Quality Assurance (NCQA) Accreditation

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

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

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

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

2.4.1 Staffing

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

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

2.4.2 Key Staff

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

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

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

The Contractor shall ensure the location of any staff or operational functions outside of the State of Indiana does not compromise the delivery of integrated services and the seamless experience for members and providers. The Contractor shall be responsible for ensuring all staff functions conducted outside of the State of Indiana are readily reportable to FSSA at all times to ensure such locations do not hinder the State's ability to monitor the Contractor's performance and compliance with Contract requirements. Indiana-based staff shall maintain a full understanding of the operations conducted outside of the State of Indiana and must be prepared to discuss these operations with FSSA upon request, including during unannounced FSSA site visits except in the circumstance of the unforeseeable loss of a key staff member's services, the Contractor shall provide written notification to FSSA of anticipated vacancies of key staff within five (5) business days of receiving the key staff person's notice to terminate employment or five (5) business days before the vacancy occurs, whichever occurs first. At that time, the Contractor shall present FSSA with an interim plan to cover the responsibilities created by the key staff vacancy. Likewise, the Contractor shall notify FSSA in writing within five (5) business days after a candidate's

acceptance to fill a key staff position or five (5) business days prior to the candidate's start date, whichever occurs first.

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

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

The key staff positions required under the Contract include:

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

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

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

Chief Information Officer (CIO) or Information Technology (IT) Director – The Contractor shall employ a CIO or IT Director who is dedicated full-time to the Contractor's Indiana Medicaid product lines. This individual will oversee the Contractor's [MLTSS Program Name] Information Technology (IT) systems and serve as a liaison between the Contractor and the State fiscal agent or other FSSA contractors regarding encounter claims submissions, capitation payment, member eligibility), enrollment and other data transmission interface and management issues. The CIO or IT Director, in close coordination with other key staff, is responsible for ensuring all program data transactions are compliant with the terms of the Contract. The CIO or IT Director is responsible for attendance at all Technical Meetings called by the State. If the CIO or IT Director is unable to attend a Technical Meeting, the CIO or IT Director shall designate a representative to take his or her place. This representative shall report back to the CIO or IT Director on the Technical Meeting's agenda and action items. For more information on the IT program requirements, see Section 9.0.

Medical Director – The Contractor shall employ the services of a Medical Director who is an Indiana-licensed Indiana Health Care Provider (IHCP) provider board certified in geriatrics, family medicine, or internal medicine. If the Medical Director is not board-certified in geriatrics, family medicine, or internal medicine they shall be supported by an Indiana licensed clinical team with experience in geriatrics, palliative care, behavioral health, and adult medicine, . The Medical

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

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

Member Services Manager – The Contractor shall employ a Member Services Manager who is dedicated full-time to member services for the [MLTSS Program Name] program, which shall be available via the member helpline and the member website, including through a member portal. The Member Services Manager shall, at a minimum, be responsible for directing the activities of the Contractor's member services, including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval, and distribution of member materials. The Member Services Manager manages the member grievances and appeals process and works closely with other managers (especially, the Quality Manager, Utilization Manager, and Medical Director) and departments to address and resolve member grievances and appeals. The Member Services Manager shall oversee the interface with the Enrollment Broker regarding such issues as member enrollment and disenrollment, member PMP assignments and changes, member eligibility, and newborn enrollment activities. The Member Services Manager shall provide an orientation and ongoing training for member services helpline representatives, at a minimum, to support accurately informing members of how the Contractor operates, availability of covered services, benefit plans and limitations, health screenings, emergency services, PMP assignment and changes, specialty provider referrals, self-referral services, preventive and enhanced services, and member grievances and appeals procedures. The Member Services Manager, in close coordination with other key staff, is responsible for ensuring that all of the Contractor's member services operations are compliant with the terms of the Contract. For more information regarding the member services program requirements, see Section 5.0. The Member Services Manager shall have prior experience in LTSS or with the program population.

Provider Services Manager – The Contractor shall employ a Provider Services Manager who is dedicated full-time to the [MLTSS Program Name] program. The Provider Services Manager shall, at a minimum, be responsible for the provider services helpline performance, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials and developing outreach

programs. The Provider Services Manager oversees the process of providing information to the State fiscal agent regarding the Contractor's provider network. The Provider Services Manager, in close coordination with other key staff, is responsible for ensuring that all of the Contractor's provider services operations are compliant with the terms of the Contract. The individual should be knowledgeable in facility licensure and IHCP enrollment. For more information regarding the provider services program requirements, see Section 6.0. Prior experience as an LTSS provider preferred.

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

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

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

Utilization Management Manager – The Contractor shall employ a Utilization Management Manager who is dedicated full-time to the [MLTSS Program Name] program. The Utilization Management Manager shall be responsible for directing the activities of the utilization management staff. With direct supervision by the Medical Director and a staff geriatrician, the Utilization Management Manager shall direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, appropriate utilization of health care services, continuity of care, and other clinical and medical management programs. The Utilization Management Manager shall work with the Special Investigation Unit (SIU) Manager to assure that service billing and utilization issues are documented and reported to the SIU, and matters requiring SIU review or investigation shall be timely submitted within five (5)

business days to enable recovery of overpayments or other appropriate action. For more information regarding the utilization management requirements, see Section 7.8. The Utilization Management Manager shall have prior experience in LTSS or with the program population.

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

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

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

including comorbidities such as dementia, intellectual and developmental disabilities, and serious mental illness diagnosis.

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

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

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

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

Transition Coordinator – The Contractor shall employ a local Transition Coordinator dedicated full-time to the [MLTSS Program Name] program who is a health care professional or who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee the initial contract member transition and all ongoing member transition issues, responsibilities and activities. The Transition Coordinator shall work closely with the transition coordination staff, providers and the State to obtain, utilize and share member transfer information to safeguard successful, timely, and orderly transitions. The Transition Coordinator shall have prior experience in LTSS or with the program population.

Member Advocate/Non-Discrimination Coordinator – The Contractor must employ a Member Advocate/Non-Discrimination Coordinator dedicated full-time to the [MLTSS Program Name] program who is responsible for the representation of members' interests including input in policy development, planning, and decision-making. Member Advocate/Non-Discrimination Coordinator

shall have knowledge and experience about HCBS consumer concerns related to HCBS providers and services and have strong conflict resolution and problem-solving skillset. The Member Advocate shall be responsible for development and oversight of the Member and Informal Caregiver Advisory Committee. This individual shall also be responsible for the Contractor's compliance with federal and state civil rights laws, regulations, rules and policies, including but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) and the Age Discrimination Act. The Member Advocate/ Non-Discrimination Coordinator shall have prior experience in LTSS or with the program population.

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

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

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

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

Housing Coordinator – The Contractor must employ a full-time Housing Coordinator dedicated to the [MLTSS Program Name] program who can work with care/case managers to assist members and work with statewide and local housing entities to find appropriate housing services and supports for members in [MLTSS Program Name]. This person shall have experience in supporting older adults and/or persons with disabilities to secure accessible, affordable housing through Federal and local programs including the Indiana Housing and Community Development Authority programs, HUD subsidized housing and voucher programs, public housing authorities, the Homeless Management Information System (HMIS), and USDA's Rural Development Single

Family and Multi-Family programs. The Housing Coordinator shall be responsible for working with the aforementioned housing agencies to help develop and access affordable housing services for members receiving LTSS, educating and assisting Care/Service Coordinators and network providers regarding affordable housing services.

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

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

2.4.3 Other Required Staff Positions

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

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

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

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

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

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

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

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

Transition Coordination Staff who is located in Indiana to support and oversee the initial contract and ongoing member transitions in and out of the various benefit plans available in the Contractor's Indiana Medicaid programs, as well as in an out of the Contractor's enrollment. 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 disease management, care management and complex case management notes.

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

Member Services Representatives a minimum of seventy (70) percent of whom are located in Indiana. The member services representatives shall coordinate communications between the Contractor and its members; respond to member inquiries; and assist all members regarding issues such as the Contractor's policies, procedures, general operations, benefit coverage and eligibility. Member services staff should have access to real time data for members, including eligibility status, benefit package, balance and transactions, primary medical provider (PMP)

assignments and all service and utilization data. Member services staff shall have the appropriate training and demonstrate full competency before interacting with members.

Member Liaison who is a single point of contact and specifically responsible for coordination with Adult Protective Services (APS), the justice system, and the relevant state ombudsman programs, and shall be located in Indiana.

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

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

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

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

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

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

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

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

Website Staff to maintain and update the Contractor's member and provider websites and member portal.

2.4.5 Staff Training and Qualifications

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

- An overview of the [MLTSS Program Name] program & associated policies and procedures, and quality goals including updates whenever changes occur;
- Person-centered thinking
- Contract requirements and state and federal requirements specific to job functions;
- In accordance with 42 CFR 422.128, training on the Contractor's policies and procedures on advance directives;
- Initial and ongoing training on identifying and handling quality of care concerns;
- Cultural competency and health equity training;
- Training on fraud and abuse and the False Claims Act;
- Health Insurance Portability and Accountability Act (HIPAA) training;
- Management of IT systems;
- Clinical protocol training for all clinical staff;
- Utilization management staff shall receive ongoing training regarding interpretation and application of the Contractor's utilization management guidelines. The ongoing training shall, at minimum, be conducted on a quarterly basis and as changes to the Contractor's utilization management guidelines and policies and procedures occur;
- Evidence based assessment processes, person-centered planning and population specific training relevant to all populations enrolled in the [MLTSS Program Name] program for all care managers and service coordinators. The Contractor shall also ensure all applicable subcontractors provide such training to their relevant staff;
- Training and education to understand abuse, neglect, exploitation and prevention including the detection, reporting, investigation and remediation procedures and requirements; and
- Training for transportation, prior authorization and member services staff on the geography of the state and location of network service providers to facilitate the approval of services and recommended providers in the most geographically appropriate location.
- Training for the Contractor's Service Coordinators around self-directions including Participant-Directed Attendant Care Services and future iterations of the program and the role and responsibilities of the Financial Management Service (FMS) by the FMS, including financial administration and supports brokerage functions.

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

2.7.7 Medical Loss Ratio

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

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

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

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

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

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

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

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

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

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

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

- Quality management, excluding cost of administering member incentives

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

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

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

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

2.8.3 Nursing Facility Supplemental Payments

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

2.8.4 LTSS and HCBS Minimum Fee Schedule

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

2.9 Subcontracts

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

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

- 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 project's requirements except for network healthcare providers or ancillary medical providers. Subcontractors may include, but are not limited to a pharmacy benefits manager, dental benefits manager, transportation broker, behavioral health organizations (BHOs) and Physician Hospital Organizations (PHOs). The Contractor may not subcontract medical utilization management activities, but pharmacy utilization management activities may be subcontracted. The Contractor shall give FSSA a written request and submit a draft contract or model provider agreement at

least ninety (90) calendar days prior to the use of a subcontractor. The request must include a written plan on continuity of services during any transition of services. If the Contractor makes subsequent changes to the duties included in the subcontractor contract, it shall notify FSSA ninety (90) calendar days prior to the revised contract effective date and submit the amendment for review and approval. FSSA has sixty (60) days to complete a review and provide an approval or denial on the use of the subcontractor to the Contractor. FSSA must approve changes in vendors for any previously approved subcontracts.

- The Contractor must seek approval from the State for utilizing vendors for member outreach or to provide direct services, medical or behavioral care to members. The Contractor is required to provide a report sixty (60) days after the end of each calendar year listing all such agreements. The report should include method of identifying members for the vendor, services provided, number of members for which each contracted vendor provided services, and standard demographics for the members who received the services.
- 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 subcontractor oversight and monitoring plan to the State for review and approval during Readiness Review and annually within sixty (60) days
- The Contractor shall provide instruction for all direct service subcontractors and providers regarding the Contractor's written procedure for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, enrollees with Limited English Proficiency. The Contractor shall provide instruction to direct service subcontractors and providers on disability access, person-centered thinking, 42 CFR 441.301(c) settings rule compliance, and ADA compliance.
- The Contractor and its subcontractors shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations, and as amended. The Contractor shall require all its subcontractors to adhere to HIPAA standard transaction requirements.
- The Contractor shall comply with all subcontract requirements specified in 42 CFR 438.230, which contains federal subcontracting requirements. All subcontracts, provider contracts, agreements or other arrangements by which the Contractor intends to deliver services required under the Contract, whether or not characterized as a subcontract under the Contract, are subject to review and approval by FSSA and must be sufficient to assure the fulfillment of the requirements of 42 CFR 434.6, which addresses general requirements for all Medicaid contracts and subcontracts. FSSA may waive its right to review subcontracts, provider contracts, agreements or other arrangements. Such waiver shall not constitute a waiver of any subcontract requirement.

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

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

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

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

2.21 Integration and Alignment of Medicare and Medicaid

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

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

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

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

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

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

2.21.1 Coordination with Medicare Generally

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

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

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

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

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

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

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

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

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

The Contractor shall ensure its systems and business processes shall support an integrated approach to care coordination and service delivery across Medicare and Medicaid programs. This

includes the capacity to receive and load all Medicare claims data, including data from its aligned D-SNP, as well as Medicare claims data made available by the state, into its relevant case management systems and processes. This data should be demonstrably accessible for the purposes of care coordination and to support the coordination of members' Medicare and Medicaid benefits.

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

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

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

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

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

- Operate an exclusively aligned plan that is limited to full-benefit dually eligible (FBDE) enrollment;
- Offer a separate plan benefit package that enrolls only partial-dually eligible Medicaid enrollees (QMB-only, SLMB-only, QI, QDWI);
- Maintain a statewide service area that operates in all Indiana counties;
- Have obtained prior CMS approval for default enrollment of members from their aligned [MLTSS Program Name] Medicaid plan upon them first becoming eligible for Medicare;
- Maintain a 3-star quality rating or above. The State will review these ratings annually as part of its quality review process.
- Meet SMAC contract requirements. Failure may result in FSSA will assessing authorized remedies for the Contractor's non-compliance as listed in Exhibit 2.

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

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

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

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

Within one year of [MLTSS Program Name] go-live, 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).

Exhibit 4 – Section 3.2 Auto-assignment to MCE

For [MLTSS Program Name] eligible members who do not select an MCE on the application, or within sixty (60) days, the State fiscal agent will auto-assign the individual to an MCE. The rules and logic for auto-assignment are created by the State and comply with 42 CFR 438.52(f). The State maintains an auto-assignment logic which considers established provider relationships and assignment of all family members to the same MCE.