# 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]". Additionally, please note that references in the excerpts to “the State” mean FSSA and references to “the Contractor” mean the MCE that would enter into a contract with FSSA to participate in the program.

## Covered Services and Care Coordination Excerpts Related to April 7th, 2022 Information Sharing Presentation

**Exhibit 6 Definitions Excerpts**

**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 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.

**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. A caregiver may be also designated by the member as a representative for consumer direction. Members may have more than one Informal Caregiver. Any paid Informal Caregivers must be enrolled as a Medicaid provider with the state and contracted and credentialed with the Contractor.

**Informal Caregiver Assessment** – With the consent of the member, the Service Coordinator shall administer an evaluation of a member’s informal caregiver, as required in Section 4.8.2, upon the member’s initial enrollment to the program, annually, and upon a significant change in member circumstances, utilizing a tool approved by the State.

**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.

**3.0 Covered Benefits and Services**

The Contractor shall provide to its [MLTSS Program Name] members, one of two packages of service. The first, State Plan Medicaid, which includes nursing facility, home health and hospice care is available to all enrolled individuals. The second, State Plan Medicaid plus Home and Community Based Services (HCBS), is available to all who have been determined to meet the Level of Care set forth in 2.1 Eligibility Requirements. State Plan Medicaid services include at a minimum, all benefits and services deemed "medically reasonable and necessary" and covered by the IHCP and included in the Indiana Administrative Code and under the Contract with the State. A covered service is considered medically necessary if it meets the definition as set forth in 405 IAC 5-2-17. HCBS services have a separate and distinct definition of medically necessary as described in Section 3.9.

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

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

**Included HCBS 1915(c) LTSS Waiver Services**

[*Please note that these services are covered for members determined eligible for HCBS waiver services*.]

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| **Included HCBS 1915(c) LTSS Waiver Services** | Please reference the most current version of the Indiana Health Care Provider manual for the most update covered services and their respective service definitions for those eligible for HCBS LTSS in the 1915(c) Managed Care Medicaid Waiver. Current list below:<br>Adult Day Service<br>Attendant Care<br>Care Management<br>Informal Caregiver Coaching and Behavioral Management* (as of 7/1/2022)<br>Home and Community Assistance<br>Respite<br>Community Home Share Assisted Living<br>Community Transition<br>Customized Living* (as of 7/1/2022)<br>Goal Engagement* (as of 7/1/2022)<br>Home Delivered Meals<br>Home Modification Assessment<br>Home Modifications<br>Integrated Health Care coordination<br>Nutritional Supplements<br>Participant Directed Attendant Care<br>Personal Emergency Response System<br>Pest Control<br>Specialized Medical Equipment and Supplies<br>Structured Family Caregiving<br>Transportation |

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| | Vehicle Modifications |

### 3.4 Emergency Services

The Contractor shall cover emergency services without the need for prior authorization or the existence of a contract with the emergency care provider. The Contractor shall reimburse out-of-network emergency providers at one hundred percent (100%) of the Medicaid rate, unless other payment arrangements are made. The Contractor is required to reimburse for the medical screening examination and facility fee for the screening but is not required to reimburse providers for services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition, unless the Contractor authorized this treatment. The Contractor shall pay the contracted or fee schedule rate for an observation stay, regardless of whether a related emergency department visit was determined emergent.

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

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

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

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

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

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

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

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

#### 3.8.1 Nursing Facility

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

The Contractor shall provide nursing facility services for members. The nursing facility must be licensed by the Indiana state department of health and enrolled with the IHCP. The contractor

must contract with any willing nursing facility provider who meets the criteria of licensure and IHCP enrollment who is willing to accept the provisions of the MCE's contract. This any willing provider requirement will be in place for the first three (3) years of contract operations.

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

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.

**3.9 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 the IHCP manual for service definitions for services that shall be considered when developing a service plan. The full listing and details on HCBS covered are available in the State's waiver and relevant IHCP modules. Additional services may be added upon CMS approval of the IHCP manual.

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

- Will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist a member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

- Will provide the opportunity for a member receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

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

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

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

Customized Living
Customized Living provides a member customized package of regularly scheduled, health-related and supportive services provided to a participant who meets eligibility requirements for nursing facility level of care, and that provides direct, hands-on assistance to members in order to meet functional health and social needs as determined by an assessment, in accordance with Department requirements and as outlined in the participant's service plan.

**3.10 Participant-Directed Attendant Care Services (PDACS)**

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

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

## 3.11 Informal Caregiver Support

### 3.11.1 Informal Caregiver Training, Education, and Resources

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

Additionally, non-waiver supports should be coordinated by the Contractor with the informal caregiver and may include providing directories and assistance in contacting community social supports, food banks, utility and housing assistance, legal services, financial services, insurance assistance, support groups, and respite services. The Contractor is encouraged to identify other community health resources and opportunities local to the member and their informal caregiver. The Contractor shall provide training, education, and resources in accessible formats to ensure access for the informal caregivers. Example formats include, but are not limited to, in-person meetings, telephonic and web platforms, written toolkits and guidebooks. In addition, the Contractor shall observe the communication requirements in Section 5.4. Member Information, Education and Outreach.

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

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

- Health conditions.
- Advance Care Planning: advance directives, will planning, physician orders for life sustaining treatment (POST) form, etc.
- Medications and/or medication management/assistance to prevent medication errors, if part of the care/service plan.
- Fall prevention interventions, as necessary.

- Healthcare providers including contact information.
- Emergency contacts.
- Identification and contact information for back-up informal caregiver(s).
- Contact information for Informal Caregiver Coach and Contractor Care Team.
- Informal caregiver resources available within the caregiver's/member's community of choice.

### 3.11.2 Informal Caregiver Coaching

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

## 3.12 Housing

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.

## 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 disease management 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, or ombudsman 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.

### 3.17 Non-Emergency Medical Transportation Services

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

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

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

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

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

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

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

#### 3.17.1 Non-emergency Medical Transportation Providers and Provider Network

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

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

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

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

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

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

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

### 3.17.2 NEMT Care Coordination

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

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

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

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

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

### 3.17.3 NEMT Communications

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

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

### 3.17.4 NEMT Brokers

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

### 3.17.5 Community Transportation

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

### 3.17.6 Attendant Care Aide Transportation

Transportation to both community and medical appointments is available for individuals receiving HCBS LTSS through 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.

### 3.22 Continuity of Care

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

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

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

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

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

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

### 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.

### 3.24 Enhanced Services

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

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

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

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

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

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

- Unbiased – Creating unbiased enhancements and incentives are necessary to comply with federal laws. Incentives must not leave out any groups on the basis of ethnicity, education, race, social class, ability, etc.);
- Possess equity – Equality is not enough when providing enhanced services and incentives, rather maintaining equity should also be considered (equality would be providing a pair of size 10 shoes to everyone; equity is providing a pair of the correct size shoes to everyone);
- Communicated appropriately in a timely manner – Incorporate the most appropriate and farthest reaching vehicle to communicate the enhanced benefit and incentive so as not to exclude members (e.g., lack of literacy and technology should be considered). Appropriate messaging should capture high quality outcomes;
- Be relevant – If barriers exist that prevent members from using the enhanced service and incentive, the incentive will not hold much value (e.g., a member is given a gym membership as an incentive but does not have the transportation to get to the gym).

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

**4.1 Care Coordination Program Overview**

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

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

In addition to Care Coordination services, all members who are determined Nursing Facility Level of Care (NFLOC) and receive HCBS or institutional LTSS will be eligible for Service Coordination for their LTSS and related environmental and social services. Service Coordination specifically focuses on supporting members in accessing long-term services and support, medical, social, housing, educational, and other services, regardless of the services' funding sources. All members receiving Service Coordination will have an assigned Service Coordinator who works with the member's Care Coordinator to ensure cohesive, holistic service delivery.

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

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

### 4.3 MLTSS and Medicare Care Coordination Alignment

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

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

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

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

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

Medicare and Medicaid benefits to members. The Contractor shall identify and include all necessary parties from both the [MLTSS Program Name] and its aligned D-SNP in requests and responses to avoid administrative duplication.

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

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

**4.4 Vulnerable Subpopulations**

The Contractor is expected to develop and deliver tailored services for vulnerable member populations. The Contractor's Care Coordination Program Plan must describe the most vulnerable members within the MLTSS population (i.e., what sets them apart from the overall MLTSS 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 most vulnerable 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 this vulnerable population.

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 most vulnerable members, 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 vulnerable subpopulations or groups, which the Contractor must incorporate into its vulnerable population definition and address through specially tailored services.

### 4.6 Comprehensive Health Assessment

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

a. For members who are receiving LTSS in a nursing facility at the time of enrollment, the Contractor shall conduct the Comprehensive Health Assessment or State-approved nursing facility assessment(s) (Section 4.8.1) onsite within thirty (30) calendar days of the MCE effective date.
b. For members who meet NFLOC and are either receiving HCBS, waiting to receive, or opt to receive HCBS at the time of enrollment, the Contractor shall conduct the Comprehensive Health Assessment onsite within thirty (30) calendar days of the MCE effective date.
c. For enrollees who do not meet NFLOC and are not receiving LTSS in an institutional, home, or community-based setting at the time of enrollment, the Contractor shall conduct a Comprehensive Health Assessment onsite or by phone within ninety (90) calendar days of the MCE effective date.

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

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

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

The State-developed CHAT shall include a functional assessment based on the interRAI and a social determinants of health (SDOH) questionnaire based on the Accountable Health Communities (AHC) Model. The CHAT shall also include an assessment of vulnerability and risk factors for abuse and neglect

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

As part of the Comprehensive Health Assessment process, the Contractor shall work with the member and collect and review medical and educational information, as well as family and caregiver input, as appropriate, to identify the member's care strengths, health needs and available resources. The Comprehensive Health Assessment may include, but is not limited to, a review of the member's claims history and contact with the member and/or member's family, their informal caregiver, PMP (if applicable), or other significant providers with the consent of the member. A clinician on the Contractor's Care Coordination team will review the findings of the CHAT and provide the findings to the member's ICT and primary providers, including the member's PMP and/or behavioral health care providers, as applicable.

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

The Contractor must 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.

**4.7 Reassessments**

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

In addition, members may move between stratified Care Coordination level of service groups over time as their needs change, therefore, the Contractor shall develop a protocol for re-evaluating members

periodically to determine if their present care levels are adequate. The Contractor must at minimum re-screen and conduct a Comprehensive Health Assessment within one year of the initial assessment and within one year thereafter. Additionally, any member or provider can request that a member's Care Coordination level of service be reassessed for redetermination at any time.

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

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

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

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

**4.8 LTSS-specific Assessments**

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

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

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

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

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

- An exploration with the member of the member's understanding of self-directed supports and any desire to self-manage the allowable portions of their care plan.
- An exploration with the member of the member's preferences in regard to privacy, services, caregivers, and daily routine, including, if appropriate, an evaluation of the member's need and interest in acquiring skills to perform activities of daily living to increase their capacity to live independently in the most integrated setting.
- An assessment of mental health and alcohol and other drug abuse (AODA) issues, including risk assessments of mental health and AODA status as indicated.
- An assessment of the member's overall cognition and evaluation of risk of memory impairment.
- An assessment of the availability and stability of natural supports and community supports for any part of the member's life. This shall include an assessment of what it will take to sustain, maintain and/or enhance the member's existing supports and how the services the member receives from such supports can best be coordinated with the services provided by the Contractor.
- An exploration with the member of the member's preferences and opportunities for community integration including opportunities to engage in community life, control personal resources, and receive services in the community.
- An exploration with the member of the member's preferred living situation and a risk assessment for the stability of housing and finances to sustain housing as indicated.
- An exploration with the member of the member's preferences for educational and vocational activities.
- An assessment of the member's understanding of their rights, the member's preferences for executing advance directives and whether the member has a guardian, protective order, durable power of attorney or activated power of attorney for health care.

### 4.8.2 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.

## 4.9 Individualized Care Plans

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

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

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

When developing ICPs, in conjunction with other qualified health care providers and the ICT (as applicable for members in Complex Case Management), the Contractor must ensure that there is a mechanism for members, their families, informal caregivers, or others, as chosen by the member, to be actively involved in ICP development. The ICP must reflect cultural considerations of the member. In

addition, the Care Plan development process must be conducted in plain language and be accessible to individuals with disabilities and individuals with limited English proficiency.

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

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

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

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

As part of the annual Care Coordination Program Plan, the Contractor must describe the process for developing ICPs at a minimum, including a detailed description of its chosen person-centered planning

model or process, detail how the results of the initial Comprehensive Health Assessment and annual reassessment are included in ICPs. The Contractor must provide a detailed explanation of how its stratification results are incorporated into each member's ICP.

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

#### 4.9.3 Individualized Care Plan Documentation and Distribution

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.

#### 4.10.2 Nursing Facility Service Plans

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

#### 4.10.4 Service Plan Authorization

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

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

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

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

### 4.11 Minimum Member Contact

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

#### 4.11.1 Care Management – Member Outreach and Contact

The Contractor shall establish policies and procedures that encourage all new members to have a preventive care visit within sixty (60) calendar days of the member's effective date of enrollment and ongoing member outreach as indicated for the entire population. Care Management services shall address each member's medical and health concerns, specific medical information, and available community resources. Services will typically result in brief, short-term encounters. The Contractor will reach out to members and providers during the initial assessment period as well as on an ongoing basis, via phone, in person and through written notification, as well as using community health workers, to physically make contact when members cannot be reached or when Care Management via phone is not successful. Members in Care Management services will be provided with contact phone numbers at the Contractor to call with questions.

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.

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

#### 4.11.2 Complex Case Management – Member Outreach and Contact

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

### 4.11.3 Service Coordination – HCBS Minimum Contacts

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

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

Members shall be contacted by their Service Coordinator at least monthly either in person or by telephone, unless the member specifically requests to opt out or otherwise reduce the frequency of these monthly contacts. The Service Coordinator may also meet more frequently with the member when appropriate based on the member's needs and/or request.

### 4.11.4 Service Coordination – NF Minimum Contacts

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

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

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

## 4.12 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.

### 4.13.3 Care Coordinator Training Requirements

In addition to the required Learning Community training (see Section 4.13.2), the Contractor must provide orientation and training to newly hired Care Coordinators in a minimum of the following areas:

- Medicaid;
- Quality assurance;
- Quality improvement;
- An overview of the MLTSS program;
- The continuum of LTSS services, including available service delivery options, placement settings and service restrictions/limitations;
- Assessment processes, person-centered care planning, and care plan development and updates and population specific training relevant to the populations enrolled in the [MLTSS Program Name]; including training on applicable tools and protocols;
- Member rights and responsibilities;
- The federal regulations for the Security and Privacy of Protected Health Information found at 45 CFR Part 164 (HIPAA) and for the Confidentiality of Substance Use Disorder Patient Records found at 42 CFR Part 2;
- Self-direction of health care tasks;
- Coordination of care for dual eligible members;
- Critical incident reporting;
- Cultural competency;
- Housing and employment services;
- Responsibilities related to recognizing, screening, monitoring for, and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect, self-neglect, and/or exploitation as defined in 455 IAC. 2-4-2; 455 IAC. 1-2-2(g-h) and in alignment with [MLTSS Program Name] requirements in Section 5.13;
- Individualized Care Plan documentation standards;
- End of life person centered planning, Advance Directives, including training in Physician (or Medical) Orders for Life-Sustaining Treatment (POLST or MOLST) or Physician Orders for Scope of Treatment (POST), and services and supports including covered services and how to access those services within the Contractor's network;

- Information on the beneficiary support system, including but not limited to how to obtain assistance with choice counseling, filing grievances, complaints, or appeals, finding the status of a complaint or appeal, and resolving issues related to rights and responsibilities;
- Conducting a home visit and use of monitoring checklists and/or tools;
- Engaging and supporting informal caregivers;
- Population health;
- Behavioral health information, including identification of member's behavioral health needs, covered behavioral health services, how to access those services within the Contractor's network, the requirements for initial and quarterly behavioral health consultations, processes for making referrals for SMI determinations, and standards for the provision of services for members determined to have an SMI;
- Management of critical transitions (including hospital discharge planning), Nursing facility to community transitions, including training on tools and protocols and the Pre-Admission Screening and Resident Review (PASRR) process;
- Hearing and appeals;
- The 4Ms (Mentation, Mobility, Medications, and What Matters) of Age Friendly Health Systems;

### 4.17 Interdisciplinary Care Team (ICT)

Under [MLTSS Program Name], the Contractor must use an ICT for the coordination of care for each member assigned to the Complex Case Management level of service. Where there is no conflict with [MLTSS Program Name] requirements in this Section, the Contractor shall use its companion D-SNP's CMS-approved MOC to provide ICT services. In cases where the Contractor's companion D-SNP's CMS-approved MOC does not meet Indiana [MLTSS Program Name] standards, the Contractor shall modify or adapt its companion D-SNP's CMS-approved MOC approaches to meet the requirements in Section 4.17 when delivering ICT services to [MLTSS Program Name] members who are assigned to Complex Case Management.

#### 4.17.1 ICT Participants

For [MLTSS Program Name] members who qualify for an ICT, the Contractor must use an ICT skilled in nursing, social work and behavioral health, with knowledge of local community resources to implement protocol-driven care modules for members. This will include action steps to be followed when needs are identified. The ICT is responsible for the initial assessment and on-going re-assessment and evaluation of qualified members. At a minimum, a member's ICT must include the following:

1. The member
2. The member's Care Coordinator
3. The member's Service Coordinator (applicable only for members who are NFLOC and receive LTSS)
4. Any member-selected supports, including informal caregivers

The Contractor must incorporate additional expertise as needed based on the person's medical and behavioral health conditions, disabilities, pharmacy, environmental needs, and other urgent management needs. Additional resources and ICT participants may include, but are not limited to:

- The member's PMP if requested by the member or the facility's medical director as applicable
- Participants from the member's facility's care team if the member resides in a facility
- Physician(s), Nurse Practitioner and/or Physician Assistant's involved in the care of the member or who have relevant expertise to assist the member and ICT
- Physical therapists
- Occupational therapists
- Speech/language therapists
- Nutritionists or registered dieticians
- Pharmacists with polypharmacy or geriatric experience
- Mental health specialists

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.

**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. In accordance with Section 2.21, the Contractor shall designate the member's Care Coordinator as the single point of coordination on the member's Integrated Care Team (ICT) for its dually-eligible members enrolled in its aligned D-SNP to coordinate member care across Medicaid and Medicare.

As part of the annual Care Coordination Program review process, the Contractor must describe how 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.