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.

Provider Network Excerpts Related to April 19th, 2022 Information Sharing Presentation

6.1.1 LTSS Network Development and Management Plan

The Contractor shall develop and maintain a Network Development and Management Plan (NDMP) demonstrating the Contractor has adequate LTSS and HCBS provider capacity to meet the needs of each [MLTSS Program Name] member meeting Nursing Facility Level of Care (NFLOC). The Contractor shall demonstrate that they are able to serve members regardless of the county in which the member lives. Additionally, the Contractor must also meet minimum enrollee-to-provider ratios listed in the table below for each county. [42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2)].

The Contractor shall continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, utilization of services, member satisfaction surveys, and demographic data requirements. The Contractor shall also develop non-financial incentive programs to increase participation in its provider network when feasible. [42 CFR 438.604(a)(5); 42 CFR 438.606; 42 CFR 438.207(b); 42 CFR 438.206]. The Contractor shall include in the NDMP its practices for transitioning from fee-for-service to [MLTSS Program Name] and how a member’s needs shall be met if services are not available in the Contractor’s network.

The submission of the NDMP to the State is an assurance of the adequacy and sufficiency of the Contractor’s provider network. The NDMP shall be evaluated, updated and submitted to the State annually and include the following minimum elements:

a. Summary of nursing facility provider network, by county;

b. Summary of HCBS provider network, including, by service and county for both the minimum of two (2) providers per county and the required enrollee to provider ratios;

c. Description and demonstration of monitoring activities to ensure that LTSS-specific access standards are met;

d. Demonstration of the Contractor's ongoing activities to identify each needed service, consistent with the member's service plan and the requirements of this contract, that could not be delivered due to inadequate provider capacity (service gaps). The Contractor shall document the process to analyze service gaps, identify systemic issues and implement remediation and quality improvement (QI) activities. This shall include a summary of provider network capacity issues by service and county, the Contractor's remediation, and QI activities and the targeted and actual completion dates for those activities;

e. Demonstration of the Contractor's efforts to develop an expanded network of community-based residential alternatives, for enrollees of [MLTSS Program Name]. The Contractor shall report provider recruitment activities and provide a status update on capacity building; and

f. Description of the Contractor's ongoing HCBS provider development activities taking into consideration identified provider capacity, network deficiencies, and service delivery issues and future growth in members needing LTSS.

Following the first quarter of implementation, the State will review all relevant reports submitted by the Contractor, including, but not limited to provider network capacity, timely service initiation capacity, timely service initiation service gaps, service utilization and continuity of care. The State will use the data provided in these reports to further establish LTSS provider capacity requirements and develop performance standards, benchmarks and associated liquidated damages for non-compliance.

6.1.2 Access to Culturally and Linguistically Competent Providers

To the extent possible, the Contractor shall provide members with access to providers who are culturally and linguistically competent in the language and culture of the member.

The Contractor shall develop, implement, and monitor policies that require network providers to demonstrate that they are making necessary accommodations in providing services, employing appropriate language when referring to and talking with people with disabilities, and understanding communication, transportation, scheduling, structural, and attitudinal barriers to accessing services.

6.2 Network Composition Requirements

In compliance with 42 CFR 438.207, which provides assurances of adequate capacity and services, the Contractor shall:

- Serve the expected enrollment;
- Offer an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled; and
- Maintain a sufficient number, mix and geographic distribution of providers as specified below.

At the beginning of its Contract with the State, the Contractor shall submit regular network access reports as directed by FSSA. Once the Contractor demonstrates compliance with FSSA's access standards, the Contractor shall submit network access reports on an annual basis and at any time there is a significant change to the provider network (i.e., the Contractor no longer meets the network access standards). The

Contractor shall comply with the policies and procedures for network access reports set forth in [MLTSS Program Name] MCE Reporting Manuals. FSSA shall have the right to expand or revise the network requirements, as it deems appropriate.

As required under 42 CFR 438.206, the Contractor shall ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members, if the Contractor also serves commercial members. The Contractor shall also make covered services available twenty-four (24)-hours-a-day, seven (7)-days-a-week, when medically necessary. In meeting these requirements, the Contractor shall:

- Establish mechanisms to ensure compliance by providers;
- Monitor providers regularly to determine compliance; and
- Take corrective action if there is a failure to comply.

The Contractor shall provide FSSA written notice at least ninety (90) calendar days in advance of the Contractor's inability to maintain a sufficient network in any county. FSSA shall have the right to expand or revise the network requirements, as it deems appropriate.

In addition to the specific Network Composition requirements listed below, the Contractor shall also meet or exceed the following:

- Contract with a minimum of 90% of IHCP enrolled acute care hospitals located in the State of Indiana.
- Contract with a minimum of 90% of IHCP enrolled Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) located in the State of Indiana.
- Contract with a minimum of 90% of IHCP enrolled Community Mental Health Centers (CMHC) located in the State of Indiana.
- Meet or exceed the following provider-to-member ratios:
    - 1:1,000 for PMPs (includes all physician and advanced practice nurses enrolled as a PMP with the Contractor)
    - 1:1,000 for Behavioral Health Providers (excluding physicians, CMHCs, and inpatient)
    - 1:2,000 for Gynecologists
    - 1:2,000 for Dentists
    - 1:5,000 for Anesthesiology, Cardiology, Endocrinology, Gastroenterology, Geriatricians, Nephrology, Ophthalmology, Orthopedic Surgery, General Surgery, Pulmonology, Rheumatology, Psychiatry, Urology, Infectious Disease, Otolaryngology, Oncology, Dermatology, and Physiatry/Rehabilitative
    - Meet or exceed the requirements and provider-to-member ratios for HCBS and LTSS services listed below.

Service Type	Requirement

Extended Facility (Skilled Nursing Facility)	One facility located in each county
Home Health	1:150 and at least two serving each county
Hospice	1:400 and at least two serving each county
Adult Day	Contract with 90% of IHCP enrolled providers
Adult Family	Contract with 90% of IHCP enrolled providers
Assisted Living	Contract with 90% of IHCP enrolled providers
Attendant Care	1:400 and at least one provider serving each county
Service Coordination	1:300 and at least one provider serving each county
Structured Family Care	1:400 and at least one provider serving each county
Community Transitions	1:300 and at least one provider serving each county
Personal Emergency Response	1:400 and at least one provider serving each county
Integrated Healthcare Coordination	1:300 and at least one provider serving each county
Home Delivered Meals	1:200 and at least one provider serving each county
Home Modifications	1:400 and at least one provider serving each county
Home & Community Assistance	1:400 and at least one provider serving each county
Community Transportation	1:200 and at least one provider serving each county
Nutritional Supplements	1:400 and at least one provider serving each county
Pest Control	1:400 and at least one provider serving each county
Respite	1:150 and at least one provider serving each county
Specialized Medical Equipment	1:200 and at least one provider serving each county
Vehicle Modification	1:200 and at least one provider serving each county

6.2.17 Skilled Nursing Facilities

The Contractor must maintain the adequacy of its Provider Network sufficient to provide Enrollees with reasonable choice within each county of the Contracting Area, provided that each Network Provider meets all applicable State and federal requirements for participation in the Program. For the first three (3) years of the program, the Contractor shall accept into their network any skilled nursing facility that agrees to the Contractor's standard provider agreement and meets all applicable State and Federal participation requirements.

6.2.18 LTSS Providers

For Providers of each of the LTSS Covered Services identified in Section 3.0, the Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area. For the first three (3) years of the program, the Contractor shall accept into their network any LTSS or HCBS provider that agrees to the Contractor's standard provider agreement and meets all applicable State and Federal participation requirements.

6.3 Workforce Development

The Contractor shall have a program to monitor and assess current workforce capacity and capability, forecast and plan future workforce capacities and capabilities and when indicated, deliver technical assistance to provider organizations to strengthen their workforce development programs. The Contractor shall develop and implement a workforce development strategy that is consistent with and complementary to FSSA's workforce plan and make that plan available to the public. The Contractor shall conduct efforts in support of FSSA's workforce plan.

The Contractor shall collaborate with FSSA and other agencies on any workforce development activities. The Contractor shall develop and deploy data collection and information processing resources for

assessing the current level of workforce capacity and capability strengths and deficits as well as forecasting and planning strategies that address future workforce requirements.

The State reserves the right to include workforce development related measures as part of the program Pay for Performance stipulated in Exhibit 2.

6.5 Provider Qualifications and Standards

The Contractor shall ensure HCBS LTSS providers meet the Division of Aging provider qualification requirements set out in 455 IAC 1-3 and in the IHCP provider manual.

6.6 Provider Enrollment and Disenrollment

Providers that will be delivering HCBS services must meet Division of Aging (DA) provider criteria and be certified by the DA before they can serve [MLTSS Program Name] enrollees. The Contractor will receive a list of qualified providers from FSSA to begin contracting processes. HCBS providers will start enrollment with the fiscal agent to be an IHCP provider, then work with MCEs to be contracted.

6.7 Provider Credentialing

The Contractor shall have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current state licensure and enrollment in the IHCP. The Contractor's credentialing and re-credentialing process for all contracted providers, excluding HCBS providers, shall meet the National Committee for Quality Assurance (NCQA) guidelines. The same provider credentialing standards must apply across all Indiana Medicaid programs.

For HCBS providers, the Contract shall not conduct a traditional NCQA credentialing process. Instead, the Contractor may review the provider's compliance with contractual requirements and the provider's eligibility to participate in the program (IHCP enrollment, etc.).

The State encourages the MCEs to make credentialing as streamlined and simple as possible for medical providers. The Contractor shall use the information outlined on IHCP MCE Practitioner Enrollment Form and IHCP MCE Hospital/Ancillary Provider Enrollment Forms during the credentialing process. The Contractor must ensure that providers agree to meet all of FSSA's and the Contractor's standards for credentialing PMPs and specialists, and maintain IHCP manual standards, including:

- Compliance with state record keeping requirements;
- FSSA's access and availability standards; and
- Other quality improvement program standards.

As provided in 42 CFR 438.214(c), the Contractor's provider credentialing and selection policies shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor shall not employ or contract with providers that have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act. The Contractor shall notify FSSA, in the manner prescribed by the State, of any credentialing applications that are denied due to program integrity related reasons.

The Contractor shall process all credentialing applications within thirty (30) calendar days of receipt of a complete application. If the Contractor delegates credentialing functions to a delegated credentialing agency, the Contractor shall ensure all credentialed providers are loaded into the Contractor's provider files and claims system within fifteen (15) calendar days of receipt from the delegated entity.

The Contractor shall outline for providers the information necessary and steps required to be credentialed with the Contractor, including what provider types require credentialing and which do not. This information should be communicated on the Contractor's public facing website and in direct correspondence with providers.

Additionally, the Contractor shall provide a portal for providers seeking credentialing that will allow the provider to communicate with the MCE, submit their credentialing documentation, and to see the status of their credentialing process.

The contractors credentialing and recredentialing process, policies and procedures must be demonstrated in readiness review.

6.9 Provider Agreements

The Contractor must have a process in place to review and authorize all network provider contracts. The Contractor must submit a model or sample contract of each type of provider agreement to OMPP for review and approval at least sixty (60) calendar days prior to the Contractor's intended use. The Contractor must notify OMPP of any changes to the sample contracts within three (3) weeks of the Contract award date. In additional to traditional medical provider agreements, the Contractor shall maintain a specific model contract to be used with HCBS providers particularly designed for their unique needs.

The Contractor shall include in all of its provider agreements provisions to ensure the continuation of benefits. The Contractor shall identify and incorporate the applicable terms of its Contract with the State and any incorporated documents. Under the terms of the provider services agreement, the provider shall agree that the applicable terms and conditions set out in the Contract, any incorporated documents, and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members. The requirement set forth in Section 2.9 that subcontractors indemnify and hold harmless the State of Indiana does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

In addition to the applicable requirements for subcontracts in Section 2.9, the provider agreements shall meet the following requirements:

- Describe a written provider claim dispute resolution process.
- Require each provider to maintain a current IHCP provider agreement and to be duly licensed in accordance with the appropriate state licensing board and remain in good standing with said board, when applicable.
- Require each provider to submit all claims that do not involve a third-party payer for services rendered to the Contractor's members within ninety (90) calendar days or less from the date of service. The Contractor shall waive the timely filing requirement in the case of claims for members with retroactive coverage.
- Allow each provider to utilize the Indiana Health Coverage Program Prior Authorization Request Form available on the Indiana Medicaid website for submission of prior authorization requests to the Contractor.
- Include a termination clause stipulating that the Contractor shall terminate its contractual relationship with the provider as soon as the Contractor has knowledge that the provider's license or IHCP provider agreement has terminated.

- Terminate the provider's agreement to serve the Contractor's Program members at the end of the Contract with the State.

- Monitor providers and apply corrective actions for those who are out of compliance with FSSA's or the Contractor's standards.

- Obligate the terminating provider to submit all encounter claims for services rendered to the Contractor's members while serving as the Contractor's network provider and provide or reference the Contractor's technical specifications for the submission of such encounter data.

- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors.

- Provide the PMP with the option to terminate the agreement without cause with advance notice to the Contractor. Said advance notice shall not have to be more that ninety (90) calendar days.

- Provide a copy of a member's medical record at no charge upon reasonable request by the member, and facilitate the transfer of the member's medical record to another provider at the member's request.

- Require each provider to agree that it shall not seek payment from the State for any service rendered to a Program member under the agreement.

- For behavioral health providers, require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven (7) calendar days from the date of the member's discharge.

The Contractor shall have written policies and procedures for registering and responding to claims disputes for out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6-1.

6.11 Provider Education and Outreach

The Contractor shall provide ongoing education to the provider network on the program as well as Contractor-specific policies and procedures. The Contractor shall develop an education and training workplan for contracted providers regarding key requirements of this Contract and the specific training requirements for providers of LTSS s as specified in this section. The education and training workplan shall be submitted annually to FSSA as further described in the Reporting Manual. In addition to developing its own provider education and outreach materials, the Contractor shall be required to coordinate with FSSA-sponsored provider outreach activities upon request.

Education and training regarding the Contractor-specific policies and procedures shall occur for providers of LTSS no later than thirty (30) days prior to implementation of this Contract and ongoing upon initial provider contracting. The Contractor shall offer education and training regarding the Contractor-specific policies and procedures for all contracted providers regarding provider requirements and responsibilities, the Contractor's prior authorization policies and procedures, clinical protocols, caring for vulnerable populations, aging populations, person-centered standards, member's rights and responsibilities, claims submission process, claims dispute resolution process, pay-for-outcomes programs and any other information relevant to improving the services provided to the Contractor's members and as described in the Provider Policy and Procedure Manual and Section 6.11.2.

The Contractor will ensure that providers of long-term services and supports maintain a level of training appropriate to the services that they provide. The Contractor will identify areas where the need for further provider training is evident and share information with providers about available resources and training. Contractors shall ensure that providers have access to training programs. Contractors shall

specifically assess and/or provide resources and training programs to train all long-term services and supports personnel in the prevention and detection of all forms of abuse and neglect and to assist professionals and informal caregivers to prevent and manage stress and burnout, person-centered thinking, and 42 CFR 441.301(c) settings rule compliance as applicable.

6.12 Contractor Communications with Providers

The Contractor shall notify providers of planned and unexpected systems outages which affect provider's ability to submit claims or communicate with the Contractor's provider services helpline. Notification of the systems outage shall be placed on the Contractor's provider website within two hours of identification.

6.12.1 Provider Website

The Contractor shall develop and maintain a website in an FSSA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines for network and out-of-network providers. The website shall be live and meet the requirements of this section on the effective date of the Contract. OMPP shall pre-approve the Contractor's website information and graphic presentations. The Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website described in Section 5.7.3.

To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor shall date each web page, change the date with each revision and allow users print access to the information. The provider website may have secured information available to network providers but shall, at a minimum, have the following information available to all providers:

- Contractor's contact information;
- Provider Policy and Procedure Manual and associated forms;
- All of Contractor's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic;
- The Contractor's preferred drug list;
- Claim submission information including, but not limited to the Contractor submission and processing requirements, paper and electronic submission procedures, emergency room auto-pay lists and frequently asked questions;
- Provider claims dispute resolution procedures for contracted and out-of-network providers;
- Prior authorization procedures, including a complete list of services which require prior authorization and a function to search to see if a service requires authorization
- Appeal procedures;
- Entire network provider listings;
- Links to FSSA and OMPP websites for general Medicaid and [MLTSS Program Name] information;
- HIPAA and 42 CFR Part 2 Privacy Policy and Procedures; and
- Network participation request information including all of the information, steps and forms that are required from the provider for a request to join the Contractor's network and be credentialed.

[Please note related to the excerpt below that additional information about service authorization availability will be shared in subsequent excerpts from other sections of the Scope of Work]

6.12.3 Provider Services Helpline

The Contractor shall maintain a toll-free telephone helpline for all providers with questions, concerns or complaints. A portion of the provider helpline staff (proportionate to call volume) shall be dedicated and specially trained to assist the needs of LTSS and HCBS providers. With the exception of the holidays listed below, the Contractor shall staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a twelve (12)-hour business day, from 8 a.m. to 8 p.m. Eastern, Monday through Friday. The provider helpline may be closed on the following holidays: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas.