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.

Quality, Reporting, and Compliance Excerpts Related to April 27th, 2022 Information Sharing Presentation

7.0 Quality Improvement

FSSA has established the following Program Quality Goals, which shall remain in effect for the duration of this Contract:

> [MLTSS Program Name] Quality Goals:
>
> (1) Develop service plans and deliver services in a manner that is person-centered, member-driven, holistic, involves caregivers, and addresses SDOH.
>
> (2) Ensure continuity of care and seamless experiences for members as they transition into the [Program Name] or among providers, settings, or coverage types.
>
> (3) Assure timely access to appropriate services and supports to enable members to live in their setting of choice and promote their well-being and quality of life.

7.1 Quality Management and Improvement Program

In accordance with NCQA and CMS standards, as well as the State-defined elements listed below, Contractor shall develop and implement an ongoing Quality Management and Improvement Program (QMIP) for all services it provides to its members. The program shall be comprehensive in range and scope, and it shall cover all demographic groups, care settings and types of services. The program must

be uniquely designed to serve Contractor's [MLTSS Program Name] members and must not be combined with quality programs for other Indiana Medicaid programs, other states, or other lines of business.

Through its QMIP, Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services and long-term services and supports to members.

The Contractor's QMIP shall address and support the [MLTSS Program Name] Program Quality Goals as a core component. The QMIP must also support quality improvement more broadly. To that end, the Contractor must perform the activities listed below and must address each of these elements in its annual QMIP and Work Plan:

1. Measure and report to the State on its performance, using standard measures required by the State or CMS, to determine the quality and appropriateness of care and services furnished to all enrollees;

2. Complete [up to 3] State-specified quality improvement projects (QIPs) each year, including any QIPs defined by CMS, in the manner and timeframes specified by the State and in accordance with CMS requirements set forth at 42 CFR 438.330(d)(1);

3. Implement up to three (3) State-defined initiatives or interventions annually, in collaboration with other contractors and in addition to those interventions implemented under QIPs', in support of the [MLTSS Program Name] Quality Program Goals;

4. Design and implement at least one specific and measurable initiative, approved by the State, to support each of the State-defined [MLTSS Program Name] Quality Program Goal objectives for that year as well as establish ongoing program activities that support each objective;

5. Include at least one initiative, consistent with the requirements in Section 6.1, each year to address equity

6. Actively participate in and contribute to program-wide quality improvement activities including FSSA's established quality improvement committees and to the design of quality improvement initiatives and interventions, in collaboration with other contractors and the State;

7. Use the results of quality management and improvement program activities to design improvement activities to support the quality of all Covered Benefits under the program, including long-term services and supports as well as other benefits, with appropriate input from members, informal caregivers and providers including but not limited to survey data, call center data, complaint and grievance data, and input from the Member Advisory Committee; and

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

The [MLTSS Program Name] MCE Reporting Manuals contain additional specifications regarding the annual QMIP Work Plan and Quality Improvement Plans, which may be amended from time to time by the State. The Contractor shall provide quality program progress reports to the State on no less than a quarterly basis. The Contractor must be prepared to periodically report on its quality management activities to the State's Quality Strategy Committee.

7.1.5 Quality Management and Improvement Committees

Contractor shall form and operate a regular committee structure to oversee its quality programs and shall participate in FSSA committees to support quality efforts program-wide, as follows.

7.1.5.1 Quality Management and Improvement Committee

The Contractor shall establish an [MLTSS Program Name] Quality Management and Improvement Committee to develop, approve, implement, monitor, and evaluate the QMIP and Work Plan. This committee may not be combined with the quality committee(s) for any other Indiana Medicaid programs operated by Contractor, or for other states or lines of business. The committee shall recommend policy decisions, ensure providers are involved in the quality management and improvement program, institute needed action, and ensure that appropriate follow-up occurs. The Contractor's Medical Director, LTSS Program Manager, and Pharmacy Director shall be active members in Contractor's [MLTSS Program Name] Quality Management and Improvement Committee. The committee shall be representative of management staff, including provider relations, LTSS support staff, and other department heads, as well as include stakeholders such as members, aging and disability-led advocacy groups, medical and behavioral health providers, LTSS providers, community partners, advocates, caregivers, and subcontractors, as appropriate. Subcontractors providing delegated direct services to members shall be represented on the committee.

7.1.5.2 Indiana Aging and LTSS Advisory Committee

FSSA will form and convene a quarterly independent Aging and LTSS Advisory Committee before the end of the first year of the program. This committee will include a cross-representation of members, caregivers (formal and informal), member advocates, aging and disability-led advocacy groups, subject matter experts, and other independent stakeholders. This committee will provide recommendations and proposals for the development of quality measures, reporting requirements, transparency and data requirements, and value-based reimbursement methodologies to State staff. Additionally, the committee will be a venue to discuss concerns relating to service by providers and the Managed Care Entities to meet member needs. As appropriate, the Aging and LTSS Advisory Committee should consult with the External Quality Review Organization contractor in order to align quality goals and measures. The Contractor will not have voting membership on the committee but must send designees to all committees to support the work.

7.1.10 Cooperation with the State

The FSSA shall conduct ongoing monitoring of the Contractor, as required by 42 CFR 438.66(a) and (b), to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of the FSSA and may include, but is not limited to, both scheduled and unannounced onsite visits, review of policies and procedures and performance reporting.

These monitoring procedures will include, but are not limited to, operations related to the following [42 CFR 438.66(c)(1) – (12)]:

1. Member enrollment and disenrollment,
2. Processing member grievances and appeals,

3. Processing Provider Claim Disputes and Appeals,
4. Findings from the State's External Quality Review process,
5. Results of member satisfaction surveys conducted by the Contractor,
6. Performance on required quality measures,
7. Medical management committee reports and minutes,
8. Annual quality improvement plan,
9. Audited financial and encounter data,
10. Medical loss ratio summary reports,
11. Customer service performance data, and
12. Any other data related to the provision of LTSS including the Contractor's DSNP

Reporting requirements are detailed further in Section 10.0 and the State MCE Reporting Manual.

7.1.11 Publication of Quality Performance Reports

The State reserves the right to publish Contractor-level and provider-level quality performance data and information, including but not limited to: Contractor performance related to [MLTSS Program Name] Quality Program Goals, the status and impact of quality improvement initiatives and interventions, and information regarding the status of Contractor QIPs and Corrective Action Plans (CAPs).

7.2 Surveys

The Contractor is required to perform and/or assist with the following annual surveys as described below:

- Member Surveys:
  - i. Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Health Plan, HCBS and Nursing Home
  - ii. National Core Indicators Survey- Aging and Disabilities
- Informal Caregiver Survey
- Provider Surveys

The Contractor shall incorporate and address findings from surveys and other analytic activities to assess the quality of care and services provided to members and identify opportunities for Contractor improvement. The Contractor shall submit a report (3 months after the initial survey period and annually thereafter) to FSSA summarizing the member and informal caregiver survey methods and findings and identifying opportunities for improvement. The Contractor shall participate in the delivery and/or results review of surveys as requested by the State. The State reserves the right to rely upon member survey findings as a basis for P4O and VBP.

The Contractor shall provide survey results to the State (including de-identified member-level data) from all independently administered survey, by stratifications defined by the State. The State will analyze the findings to identify required performance improvement activities and shall make the findings available to stakeholders.

Summary results of Contractor's surveys may become public information and available to all interested parties on the State's public website. The Contractor may be required to participate in workgroups and other efforts that are initiated based on the survey results. The Contractor may participate in or conduct

additional surveys based upon findings from the previously conducted surveys, as approved by the State, as part of designing its QMIP For non-required surveys, The Contractor shall provide notification and receive State approval prior to conducting the survey. The notification shall include a project scope statement, project timeline and a copy of the survey instrument.

Survey findings or performance rates for survey questions may result in regulatory action including, but not limited to, Contractor being required to develop a Corrective Action Plan (CAP) to improve areas of concern noted by the State. Failure to effectively develop or implement CAPs and drive improvement may result in non-compliance actions as described in Exhibit 2.

7.8 Utilization Management Program

The Contractor must operate and maintain its own utilization management program. The Contractor shall include utilization management measurements in their Quality Management and Improvement Program Work Plan as set forth in Section 7.1.2.

The Contractor's utilization management program shall not be limited to traditional utilization management activities, such as prior authorization. The Contractor must maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures and systems in place to assist utilization management staff to identify instances of over- and under-utilization of Emergency room services, non-emergency medical transportation services and other health care services, identify aberrant provider practice patterns (especially related to Emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams), ensure active participation of a utilization review committee, evaluate efficiency and appropriateness of service delivery, incorporate subcontractor's performance data, facilitate program management and long-term quality and identify critical quality of care issues.

The Contractor's utilization management program must link members to disease management, care management, complex case management and service coordination, as set forth in Section 4.0. This includes, but is not limited to, integrating prior authorization requests for the identification of members with real-time clinical needs. The Contractor's utilization management program must also encourage health literacy and informed, responsible medical decision making. For example, Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting. Contractors shall also be responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

The Contractor shall not delegate utilization management functions or responsibilities to subcontractors with the exception of pharmacy, vision, and/or dental. Subcontracts are subject to State approval. If the Contractor delegates some of its prior authorization function to subcontractors, the Contractor must conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures and state and federal law.

7.8.1 Utilization Management Staffing and Training

Utilization management staff must receive ongoing training regarding interpretation and application of the utilization management guidelines. The Contractor must be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by FSSA. The State reserves the right to standardize certain parts of the prior authorization reporting process across the Contractors, such as requiring the Contractors to adopt and apply the same definitions regarding pended, denied, suspended claims, etc. When adopted, these standards shall be set forth in the Reporting Manual.

When the Contractor conducts a prudent layperson review to determine whether an emergency medical condition exists, the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field.

Clinical professionals who have appropriate clinical expertise in the treatment of a member's condition or disease must make all decisions to deny a service authorization request (a request for the provision of a service by or on behalf of a member) or to authorize a service in an amount, duration or scope that is less than requested. The Contractor shall have a full time Geriatrician on staff or physician with ten (10) years of clinical practice with older adults with oversight of utilization management to review all denials of prior authorization requests. Only physicians and nurses licensed in Indiana may deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.

The Contractor shall not provide incentives to utilization management staff or to providers for denying, limiting or discontinuing medically necessary services. FSSA may audit Contractor denials, appeals and authorization requests. The Contractor shall adhere to the requirements and timelines for prior authorization as described in Section 3.22 regarding transitions and Continuity of Care. FSSA may waive certain administrative requirements, including prior authorization procedures, to the extent that such waivers are allowed by law and are consistent with policy objectives. The Contractor may be required to comply with such waivers and will be provided with prior notice by FSSA.

7.8.2 Medical Service and Pharmacy Prior Authorization (Non-HCBS services)

The Contractor is prohibited from arbitrarily denying or reducing the amount, duration or scope of required services solely because of diagnosis, type of illness or condition. The Contractor shall consider the status of the member when determining the amount or duration of services to approve, taking into consideration that individuals in this program are likely to need long-term therapies to maintain their current health and activities. The Contractor shall not use improvement in function as a criteria for approving continuation of services that enable the member to maintain their health status or prevent the member from experiencing a more significant decline.

The Contractor will not refer members to publicly supported health care resources as a means of avoiding costs.

For select IHCP published criteria or practice guidelines, as identified by the State, the Contractor's utilization management program cannot be more restrictive than the fee-for-service criteria and guidelines. The Contractor shall engage with the State to review already published medically necessary prior authorization criteria. The State reserves the right to further standardize prior authorization criteria, processes, administrative processes, forms/documentation and/or to require the use of a single prior authorization portal across Contractors.

The Contractor must use non-company customized versions of MCG and InterQual or other commercially available criteria when such products are used for utilization management reviews. The Contractor is expected to always use MCG and InterQual for the following utilization management reviews: acute inpatient, skilled nursing facility, acute inpatient rehabilitation, long-term acute care facility and behavioral health inpatient.

For areas not addressed by IHCP criteria and MCG/InterQual, the Contractor may develop their own practice guidelines and criteria, but it must be approved by the State and made available to the State. The Contractor must establish and maintain medical management criteria and practice guidelines in accordance with State and federal regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals and consider individual member needs. Pursuant to 42 CFR 438.210(b), the Contractor must consult with contracting health care

professionals in developing practice guidelines and must have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with the provider that requested the services when appropriate. Practice guidelines and criteria must be submitted to the State for approval prior to implementation by the Contractor through the standard document review process. The Contractor must periodically review and update the guidelines and post the guidelines on their website for member and provider viewing.

7.8.3 Special Consideration for Long Term Services and Supports (LTSS)Service Authorization

The Contractor may not interfere with the member's setting of choice once level of care is determined. For example, if a member is determined eligible for nursing facility level of care including the necessary PASSR approval, the Contractor may not deny an authorization for the member to receive necessary care in a nursing facility. Likewise, the Contractor may not deny an authorization for that same member to receive the necessary care at home instead of in a facility. This requirement only applies to a member's general preference towards facility versus non-facility care. This section does not limit the Contractor's ability to steer members to in-network providers.

7.8.4 Special Consideration for Home and Community Based Services (HCBS) Service Authorization

The Contractor's utilization management program shall include distinct policies and procedures regarding Home and Community Based Services (HCBS) and shall specify the responsibilities and scope of authority of Service Coordinators in authorizing LTSS and HCBS. The Contractor's prior authorization processes should support the provision of timely services to members and administrative efficiencies for providers with less duplication of effort and more coordinated and integrated processes and systems. The Contractor shall authorize LTSS and HCBS based on an enrollee's current needs assessment and consistent with the person-centered service plan in accordance with 42 CFR 438.210(b)(2)(iii). The prior authorization of HCBS covered benefits and services shall follow the policies and procedures as described in Section 4.0 Care Coordination. The Contractor may not require a provider to submit an additional authorization for services present in the member's person-centered service plan (the service plan is the authorization). The Contractor shall alert the relevant provider of the services approved in the person-centered service plan using the timelines specified for utilization management approvals and denials.

7.8.5 Authorization of Services and Notices of Actions

The Contractor shall have in place and follow written policies and procedures for processing authorization requests for initial and continuing authorizations of services as required by 42 CFR 438.210(b)(1). The Contractor's utilization management program policies and procedures must meet all state and federal regulations and current NCQA standards and must include appropriate timeframes for:

a. Completing initial requests for prior authorization of services;
b. Completing initial determinations of medical necessity;
c. Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per state law;
d. Notifying providers and members in writing of the Contractor's decisions on initial prior authorization requests and determinations of medical necessity following FSSA forms and templates; and
e. Notifying providers and members of the Contractor's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity.

The Contractor must provide a written notice to the member and provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. For members enrolled in an aligned DSNP the Contractor must send a single integrated decision notice in accordance with the requirements in 42 CFR 422.629. The notice must meet the requirements of 42 CFR 438.404. The notice to members must be provided at a fifth-grade reading level. The notice must be given within the timeframes described in the following paragraphs and 42 CFR 438.404(c), specifically:

a. Unless otherwise provided in 405 IAC 5-3-14 or 42 CFR 438.210(d)(1), to require a shorter timeframe, the Contractor must notify members of standard authorization decisions not pertaining to medications as expeditiously as required by the member's health condition, not to exceed seven (7) calendar days after the request for services. An extension of up to fourteen (14) calendar days is permitted if the member or provider requests an extension or if the Contractor justifies to FSSA a need for more information and explains how the extension is in the member's best interest. The Contractor will be required to provide its justification to FSSA upon request. Extensions require written notice to the member and must include the reason for the extension and the member's right to file a grievance.

b. Unless otherwise provided in 405 IAC 5-3-14, if the Contractor fails to respond to a member's prior authorization request not pertaining to medications within seven (7) calendar days of receiving all necessary documentation, the authorization is deemed to be granted.

c. For authorizations originally approved by the Contractor, if the Contractor denies continuation of services with the skilled nursing facility or long-term attendant care the Contractor must provide at least five (5) days of coverage for the services from the date of the notice of denial, to ensure the safe discharge of the member. This requirement does not apply for authorizations submitted untimely by the provider.

d. For situations in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than forty-eight (48) hours after receipt of the request for service. The Contractor may extend the forty-eight (48) hours by up to fourteen (14) calendar days if the member requests an extension or the Contractor justifies a need for additional information and how the extension is in the best interest of the member. The Contractor will be required to provide its justification to FSSA upon request.

e. For requests related to HCBS, the contractor shall make an expedited authorization decision and notice to the member within 24 hours of the decision to deny authorization for services contained in the member's Service Plan. Under no conditions may the Contractor extend that timeframe.

f. If the Contractor extends the timeframe in accordance with 42 CFR 438.210(d)(1), it must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if they disagree with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

g. For concurrent reviews within 72 hours of a non-urgent request and within 1 business day of an urgent request.

h. For decisions to terminate, suspend or reduce previously authorized covered services at least ten (10) business days before the date of action, with the following exceptions:

    1. Notice is shortened to five (5) business days if probable member fraud has been verified by the Indiana Office of the Inspector General or Attorney General.
    2. Exceptions detailed in in 42 CFR 431.213 and 431.214
    3. Notice may occur no later than the date of the action in the event of:
        a. The death of a member;
        b. The Contractor's receipt of a signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (the member must understand the result of supplying this information);
        c. The member's admission to an institution;
        d. The member's address is unknown and mail directed to him/her has no forwarding address;
        e. The member's acceptance for Medicaid services by another local jurisdiction;
        f. The member's physician prescribes the change in the level of medical care;
        g. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions; or
        h. The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs or a member has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse actions for nursing facility transfers).

i. The Contractor shall have staff available on weekends to ensure that utilization management decisions and notifications and delivered in the timelines required in this scope of work. Contractor timeliness shall be an area of enhanced auditing by the State.

The Contractor may not retroactively deny authorization for the continuation of care unless the provider submitted the authorization untimely.

The notification letters used by the Contractor must be approved by FSSA prior to use and clearly explain the following:

- The qualifications of the reviewer;
- The guidelines used and reason for denial or approval;
- The action the Contractor or its contractor has taken or intends to take;
- The reasons for the action;
- The member's right to file an appeal with the Contractor and the process for doing so;
- After the member has exhausted the Contractor's appeal process, the notice must contain the member's right to request an FSSA Fair Hearing and the process for doing so;
- Circumstances under which expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services; and

- The provider's right for a peer-to-peer utilization review conversation with the reviewer including the process for scheduling a peer-to-peer utilization review conversation and that the provider has fifteen (15) business days request a peer-to-peer conversation. A provider must be able to schedule a specific date and time for the peer-to-peer conversation to occur.

The Contractor must report its medical necessity determination decisions, in a manner prescribed by the Reporting Manual.

7.8.6 Authorization Systems and Technology

Additionally, the Contractor must establish an electronic prior authorization look-up tool that provides verification of whether a service requires authorization, including but not limited to LTSS services. This look-up tool shall be easily found on the Contractor's website and not require an account to be made by the provider to access.

9.7 Claims Processing

9.7.1 Claims Processing Capability

The Contractor shall demonstrate and maintain the capability to process and pay provider claims for services rendered to the Contractor's members, in compliance with HIPAA, including National Provider Identifier (NPI) requirements. The Contractor shall be able to price specific procedures or services (depending on the agreement between the provider(s) and the Contractor) and to maintain detailed records of remittances to providers.

The Contractor shall ensure that provider submission requirements are not burdensome and align with standard billing practices and IHCP guidance. Communication to both in and out-of-network providers shall be effective and efficient, aiming to simplify and streamline the provider experience. Contractors shall continually assess administrative billing requirements to identify onerous practices in need of change.

The Contractor shall implement claim requirements and processing rules that are consistent with IHCP manuals, modules, and bulletins. The Contractor must audit and test the claims processing system to ensure the correct use of HCBS procedure codes and modifiers for services included in the LTSS program and adhere to other auditing requirements as noted in Section 9.7.7. The Contractor shall offer provider participation in testing and auditing for accurate payment to LTSS providers. Contractors shall report to FSSA on their collaborative efforts at least ninety (90) days prior to initial contract implementation.

The Contractor shall use all applicable National Correct Coding Initiative (NCCI) edits in the processing of claims, except where State policy requires payment methodologies that contradict with NCCI edits. The Contractor shall use code sets and standards established and maintained by FSSA.

The Contractor shall develop policies and procedures to monitor claims adjudication accuracy and shall submit its policies and procedures for monitoring its claims adjudication accuracy to FSSA for review and approval.

The Contractor shall have written policies and procedures for registering and responding to claims disputes for both in-network and out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6 and as required in Section 6.11.3 Provider Dispute Resolution.

9.7.2 Compliance with State and Federal Claims Processing Regulations

The Contractor shall have a claims processing system to support electronic claims submission for both in- and out-of-network providers. The Contractor's system must process all claim types such as professional and institutional claims. The Contractor shall comply with the claims processing standards and confidentiality standards under IC 12-15-13-1.6 and IC 12-15-13-1.7, IHCP claim processing set up detailed in modules, banners, and bulletins, and any applicable federal regulations, including HIPAA regulations related to the confidentiality and submission requirements for protected health information (PHI).

Additionally, the Contractor must permit the ICD code R69 is an acceptable diagnosis code for members receiving Home and Community Based Services through the HCBS.

The Contractor shall ensure that communication with providers, particularly out-of-network providers, and submission requirements are efficient and not burdensome for any providers. The Contractor shall be prohibited from requiring out-of-network providers to establish a Contractor-specific provider number to receive payment for claims submitted. The Contractor shall not require providers to bill using any number other than the FSSA assigned Member ID number.

9.7.3 Claims Payment Timelines

The Contractor shall pay providers for covered medically necessary services rendered to the Contractor's members in accordance with the standards set forth in IC 12-15-13-1.5, 12-15-13-1.6 and IC 12-15-13-1.7, unless the Contractor and provider agree to an alternate payment schedule and method. The Contractor shall also abide by the specifications of 42 CFR 447.45(d)(5) and (d)(6), which require the Contractor to ensure that the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

The Contractor shall pay or deny electronically filed clean claims within twenty-one (21) calendar days of receipt. A "clean claim" is one in which all information required for processing the claim is present. The Contractor shall pay or deny clean paper claims within thirty (30) calendar days of receipt. If the Contractor fails to pay or deny a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, the Contractor shall also pay the provider interest at the rate set forth in IC 12-15-21-3(7)(A). The Contractor shall pay interest on all clean claims paid late (i.e., in- or out-of-network claims) and payments made inaccurately (paid upon the claim once adjudicated appropriately) for which the Contractor is responsible, unless the Contractor and provider have made alternate written payment arrangements. Unclean claims must be rejected or denied within thirty (30) days of receipt.

The out-of-network provider filing limit for submission of claims to the Contractor is six (6) months from the date of service. This conforms with the filing limit under the Medicaid State Plan (42 CFR 447.45(d)(4)). The in-network provider filing limit is established in the Contractor's provider agreements pursuant to the guidelines set forth in Section 4.9, which generally require in-network providers to submit claims within ninety (90) calendar days from the date of service. Timely filing limits are automatically waived in the instances of eligibility updates/ retroactivity, agency error, or any other condition established by FSSA in rule or policy. In addition, in accordance with 42 CFR 447.45(d)(4)(ii), if a claim for payment under Medicare has been filed in a timely manner, the Contractor may pay a claim relating to the same services within six (6) months after the provider receives notice of the disposition of the Medicare claim. The Contractor's IT systems must allow for the bypassing of timely filing limits or indication of alleged waiver for these established conditions that does not solely rely on the appeals or grievance processes outlined in this Contract.
The Contractor shall meet the requirements set forth in IC 27-13-36.2-3 and notify providers of deficiencies in claims within the set timelines in State statute.

All providers must be offered on their provider agreement the option to select Electronic Fund Transfer (EFT) for provider payments. The Contractor shall develop a plan to issue payments predominantly via EFT and submit to the State for approval. The Contractor shall pay claims via EFT and check runs at least weekly.

The Contractor shall not violate the claims payment provisions and timeframes that apply to accident and sickness insurers and HMOs under IC 27-8-5.7.

9.7.4 Rate Update Timeliness

The Contractor shall have policies and procedures in place to load new fee schedules and fee schedule updates from FSSA into their claims processing systems. The Contractor shall update fee schedules within thirty (30) days of the fee schedule effective date or date of notice of the fee schedule change, whichever is later. The Contractor shall reprocess claims back to the effective date of the fee schedule change within 30 days of loading the updating the fee schedule. Failure to adhere to this requirement will result in corrective action, as described in Exhibit 2 Contract Compliance and Pay for Outcomes.

9.7.6 Remittance Advice Requirements

The Contractor must produce a remittance advice related to the Contractor's payments and/or denials to providers and each must include at a minimum:

a. Appropriate explanatory remarks related to a payment or reason(s) for denials and adjustments,
b. A detailed explanation/description of all denials, payments and adjustments,
c. The amount billed,
d. The amount paid,
e. Application of COB and copays, and
f. Provider rights for claim disputes.

Additionally, the Contractor must include information in its remittance advice which informs providers of instructions and timeframes for the submission of claim disputes and corrected claims. The Contractor must include contact information for local provider relations team in addition to instructions and timeframes for claim disputes and corrected claims. All hard copy remittance advices must describe this information in detail. Electronic remittance advices must either direct providers to the link where this information is explained or include a supplemental file where this information is explained. The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). Any remittance advice related to an EFT must be sent to the provider, no later than the date of the EFT.

If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

In accordance with 42 CFR 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: ‘‘I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws.

9.7.7 Claims System Audits

The Contractor shall develop and implement an internal claims audit function that will include at a minimum, the following:

1. Verification that provider contracts are loaded correctly, and
2. Accuracy of payments against provider contract terms.

Audits of provider contract terms must be performed on a regular and periodic basis and consist of a random, statistically significant sampling of all contracts in effect at the time of the audit. The audit sampling methodology must be documented in policy and the Contractor shall review the Contract loading of both large groups and individual practitioners at least once every three (3) - year period in addition to any time a Contract change is initiated during that timeframe. The findings of the audits specified above must be documented and any deficiencies noted in the resulting reports must be met with corrective action.

In addition, in the event of a system change or upgrade, the Contractor shall also be required to initiate an independent audit of the Claim Payment/Health Information System. FSSA will approve the scope of this audit and may include areas such as a verification of eligibility and enrollment information loading, Contract information management (contract loading and auditing), claims processing and encounter submission processes, and will require a copy of the final audit findings.

FSSA shall have the right to perform a random sample audit of all claims and expects the Contractor to fully comply with the requirements of the audit, and provide all requested documentation, including provider claims and encounters submissions.

9.7.8 Recoupments

The Contractor's claims processes, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of fifty thousand dollars ($50,000) per provider or Tax Identification Number within a Contract Year or greater than twelve (12) months after the date of the original payment must be approved by FSSA.

The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. All replaced or voided encounters must reach adjudicated status within one hundred and twenty (120) days of the approval of the recoupment.

In accordance with IC 27-8-5.7-10 the Contractor may not recoup a claim (i.e. request a provider refund or adjust subsequent claims) more than two (2) years after the date of an overpayment, except in cases of fraud.

9.7.9 Claims System Changes

The Contractor shall ensure that changing or making major upgrades to the information systems affecting claims processing, payment or any other major business component, is accompanied by a plan which includes a timeline, milestones, and outlines adequate testing to be completed before implementation. The Contractor shall notify and provide the system change plan to FSSA for review and comment at least ninety (90) calendar days of the projected date of the change.

9.10 Electronic Visit Verification (EVV) Requirements

The Contractor shall work with FSSA, its fiscal agent, and FSSA's electronic visit verification (EVV) partner to implement an EVV solution which meets the requirements under section 12006 (a) of the 21st Century Cures Act. The Contractor must utilize the State Sponsored-EVV Solution's aggregator of EVV records when verifying the presence of EVV records for all impacted personal care and home health services during claims adjudication. The Contractor may only utilize EVV for claims payments on services determined by FSSA to require EVV and only enforce claims denials for missing or inaccurate EVV records based upon the timeframe established by FSSA.

10.0 Performance Reporting and Incentives

FSSA places great emphasis on the delivery of quality health care to members. Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered in [MLTSS Program Name]. The State will require and use various deliverables, performance targets, industry standards, national benchmarks and program-specific standards in monitoring the Contractor's performance and Outcomes, for both the Contractor's Medicaid and their Dual Eligible Special Needs Program (DSNP). During the term of the contract, the State intends to publish key performance metrics that may include but not be limited to, claims performance, prior authorization data, quality performance metrics, network adequacy and/or utilization reports. Public reporting will allow FSSA to compare and monitor plan performance as well as provide members, providers and stakeholders information to compare health plan performance.

In an effort to monitor health plan performance and member, informal caregiver, and provider satisfaction, FSSA reserves the right to conduct and publicly share survey results and other data elements collected for analysis during the term of the contract.

Additionally, beginning in year two (2) of the Contract, the State may utilize performance outcomes as a factor for auto-assignments and enrollment materials developed to facilitate member choice of an MCE.

The Contractor must have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to FSSA is accurate. In accordance with 42 CFR 438.604 and 42 CFR 438.606 all data must be certified by the Contractor's Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to one of these employees.

FSSA reserves the right to audit the Contractor's self-reported data and change reporting requirements at any time with reasonable notice. FSSA may require corrective action as outlined in Contract Exhibit 2 Contract Compliance and Pay for Outcomes for Contractor non-compliance with these and other subsequent reporting requirements and performance standards. FSSA may change the frequency of reports and may require additional reports at any time. In these situations, FSSA shall provide at least thirty (30) calendar days' notice to the Contractor before changing reporting requirements. FSSA may request ad hoc reports at any time.

10.1 Financial Reports

On an annual basis, the Contractor must submit program specific audited financial reports, separate for each managed care program (i.e., HIP, Hoosier Healthwise, Hoosier Care Connect, and [MLTSS Program Name] as applicable). The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. Audits should be performed for calendar years using data on a services incurred basis with six (6) months of claims run-out. The audit must detail the medical expense payments reported net of subcontracted administrative expenses and categorize all quality improvement spending into the allowed five categories. The audit shall review if quality

improvement spending passes the requirements under 45 CFR 158.150b. Audits should be performed for calendar years using data on a services-incurred basis with six months of claims run-out.